2021

STATE OF MONTANA

Employee Group Benefits Claim Audits

Prepared Under Contract With:
MONTANA LEGISLATIVE BRANCH, AUDIT DIVISION
PO Box 201705, Helena MT 59620-1705

LEGISLATIVE AUDIT DIVISION

Angus Maciver, Legislative Auditor
Deborah F. Butler, Legal Counsel

Deputy Legislative Auditors:
Cindy Jorgenson
William Soller

June 2022

The Legislative Audit Committee
of the Montana State Legislature:

Enclosed is the report on the claim audit of the state of Montana employee benefits plans for the two calendar years ended December 31, 2021 including:

- Allegiance – Medical
- Delta Dental – Dental
- Navitus Health Solutions – Pharmacy

The audit was conducted by Claim Technologies Incorporated under a contract between the firm and our office. The comments and recommendations contained in this report represent the views of the firm and not necessarily the Legislative Auditor.

The agency's written response to the report recommendations is included in the back of each report.

Respectfully submitted,

/s/ Angus Maciver

Angus Maciver
Legislative Auditor

21C-09

Room 160 · State Capitol Building · P.O. Box 201705 · Helena, MT · 59620-1705
Phone (406) 444-3122 · FAX (406) 444-9784 · E-Mail lad@mt.gov
https://leg.mt.gov/lad

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Comprehensive Claim Administration Audit

EXECUTIVE SUMMARY REPORT

State of Montana Medical Plans

Administered by Allegiance Benefit Plan Management

Audit Period: January 1, 2020 through December 31, 2021

Presented to

State of Montana

April 1, 2022

CLAIM TECHNOLOGIES INCORPORATED

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INTRODUCTION

This ***Executive Summary*** contains CTI's findings and recommendations from our audit of Allegiance Benefit Plan Management's (Allegiance) administration of the medical plan managed by the Health Care and Benefits Division within the Montana Department of Administration and subject to the oversight of the State of Montana Legislative Audit Division (the State). You can review the detail that supports CTI's findings and recommendations in our ***Specific Findings Report***.

CTI conducted the audit according to accepted standards and procedures for claim audits in the health insurance industry. We based our audit findings on the data and information provided by the State and Allegiance. The validity of our findings relies on the accuracy and completeness of that information. We planned and performed the audit to obtain a reasonable assurance claims were adjudicated according to the terms of the contract between Allegiance and the State as well as all approved plan documents and communications.

CTI specializes in the audit and control of health plan claim administration. Accordingly, the statements we make relate narrowly and specifically to the overall effectiveness of policies, procedures, and systems Allegiance used to pay the State's claims during the audit period. While performing the audit, CTI complied with all confidentiality, non-disclosure, and conflict of interest requirements and did not receive anything of value or any benefit of any kind other than agreed upon audit fees.

OBJECTIVES AND SCOPE

The objectives of CTI's audit of Allegiance's claim administration were to determine whether:

- Allegiance followed the terms of its contract with the State;
- Allegiance paid claims according to the provisions of the plan documents and if those provisions were clear and consistent;
- Members were eligible and covered by the State's plans at the time a service paid by Allegiance was incurred; and
- Any claim administration or eligibility maintenance systems or processes need improvement.

CTI audited Allegiance's claim administration of the State medical plans for the period of January 1, 2020 through December 31, 2021. The population of claims and amount paid during that period were:

Total Paid Amount	$259,382,450
Total Number of Claims Paid/Denied/Adjusted	802,118

The audit included the following components which are described in greater detail on the following pages:

- Operational Review and Questionnaire
- Plan Documentation Analysis
- 100% Electronic Screening with 30 Targeted Samples
- Random Sample Audit of 180 Claims
- Data Analytics

AUDIT FINDINGS AND RECOMMENDATIONS

Random Sample Findings

CTI validated claim processing accuracy based on a sample of 180 medical claims paid or denied by Allegiance during the audit period. We selected the random sample (stratified by the claim billed amount) to provide a statistical confidence level of 95% +/- 3% margin of error.

CTI's Random Sample Audit categorizes errors into key performance indicators. We use this systematic labeling of errors and calculation of performance as the basis for the benchmarks generated using results from our most recent 100 medical claim audits.

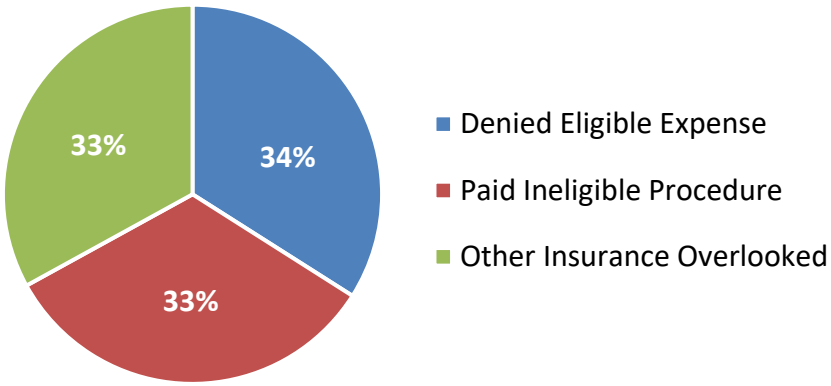
The following table illustrates Allegiance's performance was above the median in all three of CTI's benchmarked performance indicators.

Key Performance Indicators	Administrator's Performance by Quartile				
	Quartile 1	Quartile 2	MEDIAN	Quartile 3	Quartile 4
	Lowest →				*Highest*
Financial Accuracy: Compares total dollars associated with correct claim payments to total dollars of correct claim payments that should have been made.			98.55%	99.24%	
Accurate Payment: Compares number of correctly paid claims to total number of claims paid.			96.36%		98.32%
Accurate Processing: Compares number of claims processed without any type of error (financial or non-financial) to total number of claims processed.			95.64%		98.32%

Prioritization of Process Improvement Opportunities

The following chart can help to prioritize improvement and/or recovery opportunities based on savings and service impact and to pinpoint problem causes.

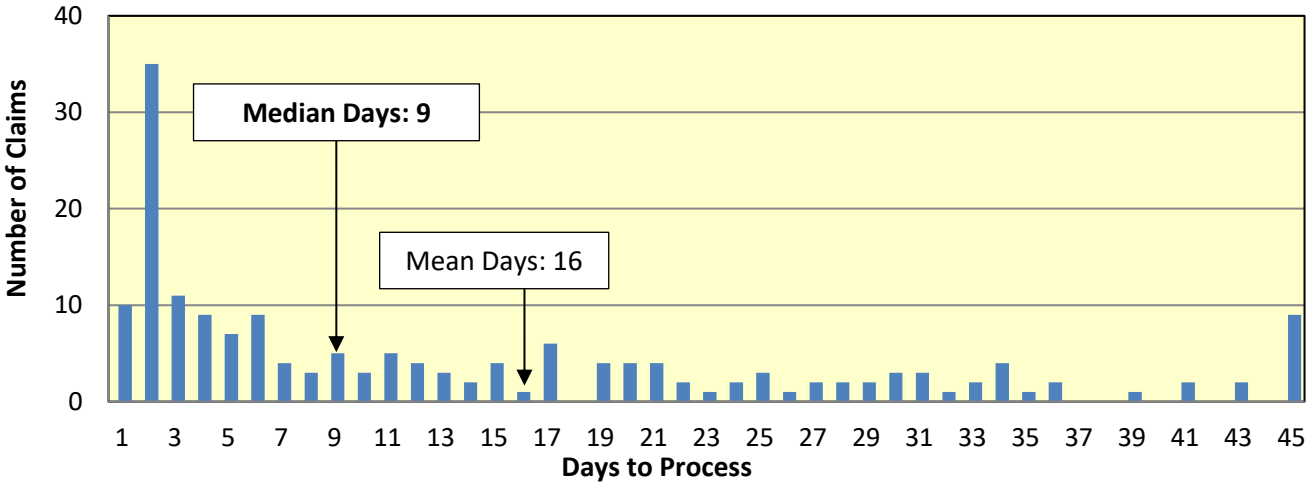
Financial and Processing Accuracy by Error Type



Claim Turnaround Time

A final measure of claim administration performance is claim turnaround time. Through the audit sample, Allegiance demonstrated its median turnaround time on a complete claim submission was 9 days from the date it received a complete claim to the date the claim was paid or denied.

Median and Mean Claim Turnaround



Random Sample Recommendation

CTI suggests the State meet with Allegiance to discuss the audit findings. Two of the three errors cited were manual errors made by claim processors. See pages 15 and 16 of the Specific Findings Report for detailed description of the errors. Focused coaching and counseling to review the correct procedures that should have been used will address those root causes. The third error was caused by a system programming error for claims involving coordination of benefits. Allegiance's response indicated that this root cause has been corrected following the date of the audit.

100% Electronic Screening with Targeted Samples Findings

We used our proprietary Electronic Screening and Analysis System (ESAS) software to further analyze claim payment accuracy as well as any opportunities for system and process improvement. Using the data file provided by Allegiance, we readjudicated each line on every claim the plan paid or denied during the audit period against the plan's benefits. Our Technical Lead Auditor tested a targeted sample of 30 claims to provide insight into Allegiance's claim administration as well as operational policies and procedures.

100% Electronic Screening with Targeted Samples Recommendations

CTI's audit did not identify any candidate cases for operational testing or for recovery. We did make one observation about the need for follow-up on an overpayment of $99,358.40 that previously had been identified by Allegiance. The audit findings indicate that Allegiance is performing at a very high level by administering plan exclusions and limitations accurately and through effective internal procedures to identify duplicate claims.

Operational Review Findings

Allegiance completed our Operational Review Questionnaire and provided information on its:

- Systems, staffing, and workflow;
- Claim administration and eligibility maintenance procedures; and

- Internal control risk mechanisms, e.g., HIPAA protections; internal audit policies and practices; and fraud, waste, and abuse detection and prevention.

We observed the following:

- Allegiance provided copies of its declaration pages for fidelity bond, errors and omissions, and cyber liability coverage. The pages showed the following coverage limits:

Policy	Coverage Limits
Employee Dishonesty/Crime Policy	$2,000,000 with $25,000 retention
Professional Liability Errors & Omissions	$5,000,000 with $100,000 retention
Cyber Liability	$5,000,000 aggregate

- Allegiance and the State have a performance agreement with guarantees for the categories of Service and Claim, Implementation, and Provider Access and Stability. Allegiance provided performance report for both 2020 and 2021 for Claim Quality and Claims Timeliness as well as for Customer Service. In 2020, Allegiance met all performance targets. In 2021, Allegiance did not achieve the target for Telephone Response Time, achieving a result of 31 seconds wait time on a weighted average basis. The goal for this measure is 30 seconds or less. Allegiance explained that the high volumes of calls related to the COVID-19 pandemic and related effects on staffing contributed to the performance result for 2021. Allegiance applied a credit to the State's March 2022 administrative fee in the amount of $28,144.80. Allegiance measured its performance specifically for the State, a best practice in contrast to administrators which report performance at a service center or book of business level.
- Allegiance indicated it had been audited for compliance with the standards of the American Institute of Certified Public Accountants (AICPA) through the issuance of a Statement on Standards for Attestation Engagements (SSAE) No. 18, reporting on controls at a service organization. Under SSAE 18, the administrator is required to provide its own description of its system, which the service auditor validates. CTI has copies of Allegiance's SOC 1 Type 2 Reports for the periods of July 1, 2019 through June 30, 2020 and July 1, 2020 through June 30, 2021. Allegiance also furnished a bridge letter from Allegiance's CFO for the remainder of calendar year 2021. We can confirm that Wipfli, Allegiance's external auditor, did not note any deviations in the installation and maintenance of customer benefits, enrollment information, and healthcare provider agreements control, or in the claim adjudication and claim payment and customer funding controls.
- Allegiance has redundant systems at a failover location. Data is backed-up nightly and stored at a secondary location. System file backups are maintained and rotated daily, weekly, monthly, quarterly, and annually. End of year backup tapes are retained indefinitely.
- Allegiance dedicates staff to serve the State. Senior staff all have more than 14 years of experience and a minimum of 5.5 years serving the State.
- Allegiance has Examiner Payment/Denial Authority Levels starting for paid or denied claims at $40,000 or more. Claims of $40,001 to $74,999 must also be reviewed by an Intermediate Examiner. Claims of $75,000 to $149,999 must be reviewed by a Senior Intermediate Examiner. Finally, claims of $150,000 to $249,999 are reviewed by the Director of Technical Claim Services and claims of $250,000 and above are reviewed by the Vice President of Technical Claims Services. Allegiance notifies the State of weekly high-dollar inpatient hospital admissions.

- Allegiance uses appropriate levels of security and control within its claim funding and checks issuance procedures to protect the plan's interest and ensure all transactions are performed by authorized personnel only. Checks are issued by Zelis.
- All Allegiance claim system users maintain unique access passwords. System access and override authority for its employees are based on job description.
- Allegiance implemented procedures for coverage of telemedicine, COVID-19 vaccines with no cost-share, and COVID-19 testing in compliance with the FFCA and CARES act.
- Allegiance has a dedicated IT team that loads an eligibility EDI file from the State. Allegiance's designated enrollment specialists are available to manage individual changes as necessary as well as review any issues or questions and coordinate corrections with the State. Eligibility is updated daily. This is a best practice and helps avoid problems caused by members whose eligibility is terminated retroactively, which is much less common with daily file updates.
- Allegiance has a State-specific procedure for determining whether dependents are disabled and still eligible to be covered by the State's plans. To be considered as disabled, members must provide Social Security documentation and tax documentation within 31 days of the date the child's coverage would be terminated as well as the member's most recent tax return which indicates the disabled child is a qualified tax dependent of the member.
- Allegiance performs Coordination of Benefits (COB) as outlined in the State's summary plan description. It provided a COB savings report for 2020 and 2021 showing $16,650,890 and $17,676,969 in savings, respectively. These amounts represent 13% of paid claims.
- 92.3% of the State's claims were submitted electronically, decreasing administrative costs and reducing the potential for manual data entry errors. However, only 55.7% of the State's claims auto-adjudicate. The lower percentage of auto adjudication is reflected in claim turnaround as observed in the random sample. The median for claims turnaround is nine days with the mean turnaround at 16 days. Both measures are within norms observed by CTI.
- Allegiance performs overpayment recovery for amounts greater than $50; however, it is unable to auto-recoup overpaid amounts from a provider's next payment. It indicated it does track the reasons for overpayment, which is a best practice.
- Allegiance maintains detailed reports showing overpayments, including amounts overpaid, amounts outstanding, and amounts reimbursed to the State. The following table illustrates overpayment recovery during the audit period.

Year	Requested Refunds	Amount Recovered	Outstanding Balance (as of Report Date)	Reimbursement Amount to the State	Amount Not Reimbursed to the State (Not yet collected, or error beyond Allegiance control)
2020	$316,711.59	$243,229.66	$68,479.93	$40,523.41	$27,977.12
2021	$491,580.03	$215,162.35	$276,417.89	NA*	$242,173.54

** Allegiance will continue to collect on all outstanding amounts and final reporting will occur early in 2023.*

- Allegiance performs subrogation by pending and issuing an accident questionnaire for all claims over $1,000. Montana law requires plan participants to be made whole prior to the plan being reimbursed. As such, the State is very rarely, if ever, reimbursed through the subrogation process

when member claims were caused by or contributed to by third-party liability. The State must approve any lien waivers or reductions, a best practice.

- Allegiance keeps an internal log to track appeal timeframes and resolution. Allegiance provided 2020 and 2021 summary reports. For 2020, there were 222 appeals, 72% of which were upheld, 21% overturned, and 7% partially upheld/overturned. 98% of appeals were handled in a timely fashion in 2020. For 2021, there were 114 appeals, 74% of which were upheld, 23% overturned, and 3% partially upheld/overturned. 97% of appeals were handled in a timely fashion in 2021, although the period for resolution of the appeal is not specified.
- Allegiance's claim system does not track the date adjustments are identified; it defaults to the original claim receipt date. As a result, adjustments are excluded from claim turnaround time calculations and the corresponding performance guarantee.
- Allegiance does not have staff dedicated to detecting and investigating fraud, waste, and abuse. Allegiance's credentialing team researches past fraud and sanctions as it is credentialing providers. Zelis' code editing service provides fraud detection, as well.
- Allegiance provided a Network Savings report showing discounts of 26.6% and 29.9% for 2020 and 2021, respectively. Network utilization was high at 98.23% in 2020 and 98.24% in 2021. The State's members traveling or domiciled outside of Montana can access Cigna's OAP network which helps drive network savings.
- Allegiance compensates out-of-network providers using a fee schedule based on the percentage of Medicare used for all service reimbursements. The State's reference-based pricing network is the primary driver of network savings.
- Allegiance has appropriate levels of security and controls in place to protect the State's medical plan records and data and was compliant with HIPAA requirements at the time of the audit.
- Allegiance's Privacy Officer oversees HIPAA compliance at Allegiance.
- Allegiance employees receive online HIPAA training annually and occasionally more often.
- During the audit period, Allegiance reported it did not have any breaches triggering notification requirements for the State.

Operational Review Recommendations

- Allegiance should consider implementing the functionality to auto-recoup overpayments from a provider's next payment. Auto-recoup capability eliminates the need for manual solicitation of refunds for overpayments and improves the timeliness of reconciliation.
- Allegiance should consider enhancements to its claims processing system to track the dates adjustments are identified. Because the current system does not have this functionality, adjusted claims are excluded from the calculation of turnaround time and the corresponding performance guarantee. Addressing adjustments would provide the State with a more accurate picture of overall claims processing timeliness.
- Allegiance should consider dedicating staff to investigation, identification, and pursuit of potential fraud, waste, and abuse. The current practice of relying on code edits and using prior sanctions for provider credentialing is not as comprehensive an anti-fraud program as CTI observes with our audits of other administrators.

Plan Documentation Analysis Findings and Recommendations

Our Plan Documentation Analysis did not find any missing or ambiguous provisions in our review of the State's plan documents.

Data Analytics Findings

CTI used electronic claim data provided by Allegiance to identify improvement opportunities and potential recoveries. The informational categories we analyzed include:

- Network Provider Utilization and Discount Savings;
- Sanctioned Provider Identification;
- Patient Protection and Affordable Care Act (PPACA) Preventive Services Payment Compliance;
- National Correct Coding Initiative (NCCI) Editing Compliance; and
- Global Surgery Prohibited Fee Period Analysis.

Network Provider Utilization and Discount Savings

CTI compared submitted charges to allowable charges for all claims paid for the plan during the audit period. The analysis relied on data provided by Allegiance and we made no assumptions when requested data fields were not provided. The following table shows the results of CTI's analysis of the value of discounts given by network providers as a percentage of all claims processed during the audit period. Paid claims totals do not include claims paid for members 65 and older.

The State's members had network utilization of 98.9% of all allowed charges and 93.0% of all claims.

Total of All Claims				
Claim Type	Allowed Amount	Provider Discount		Paid
Ancillary	$12,876,932	$5,747,634	30.9%	$10,824,667
Non-Facility	$99,641,683	$44,837,090	31.0%	$78,336,567
Facility Inpatient	$57,855,693	$20,055,539	25.7%	$54,396,171
Facility Outpatient	$105,172,616	$41,853,892	28.5%	$86,645,117
Total	**$275,546,923**	**$112,494,154**	29.0%	**$230,202,523**

Sanctioned Provider Identification

CTI screened 100% of non-facility provider claims from Allegiance against the Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE). No claims were paid to sanctioned providers during the audit period.

PPACA Preventive Services Coverage Compliance

Federal healthcare reform (PPACA) mandates that all health plans (unless grandfathered) cover certain preventive services at 100% without cost-share if a network provider performs the service.

CTI's analysis found 94.82% of procedure codes identified as preventive services were paid by Allegiance at 100% when provided in-network. CTI can provide a detailed list of the other 5.18% upon request.

NCCI Editing Capability

CTI analyzed Allegiance's claim system code editing capability to determine the degree to which it conformed to the Centers for Medicare & Medicaid Services' (CMS) NCCI guidelines used for Medicare Part B and Medicaid claims.

While not mandatory for non-Medicare/Medicaid plans, it is important to understand the benefit and potential value of these initiatives. The two CMS initiatives offering the greatest return to self-funded benefit plans are Procedure-to-Procedure Edits and Medically Unlikely Edits.

Our claim system code editing analysis identified claims for services submitted to the State and paid by Allegiance that CMS would have denied using the NCCI edits. Since Allegiance paid the billed charges, the payments represent a potential savings opportunity to the State.

Claim System Code Editing Capability Analysis by CMS NCCI Initiative		
	Procedure-to-Procedure Edits	**Medically Unlikely Edits**
Facility	$433,903	$445,041
Non-Facility	$36,811	$385,447
Ancillary	N/A	$202,998

Global Surgery Prohibited Fee Period Analysis

CTI's claim system code editing analysis identified evaluation and management (E/M) procedure codes that were submitted and paid by Allegiance that CMS would have denied using its defined global surgery fees. Payment of post-surgery E/M (office visits) services that should have been submitted as part of the physician's surgery charge is an example of unbundling, a provider billing practice that drives up cost. Since Allegiance paid allowed charges, those payments represent a potential savings opportunity to the State.

E/M Services Using Same Provider ID as Surgeon Within Prohibited Global Fee Period	
CMS Would Deny *E/M Procedure Codes without Modifier 24, 25 or 57*	
Total Count (0/10/90 days)	**Allowed Charge**
82	$11,052

Data Analytics Recommendations

The State should use the information provided from the Data Analytics findings to talk to Allegiance about the potential for additional cost savings to the plan. While Allegiance has the majority of the CMS edits in place and correctly denied claims billed inappropriately, CTI found $1,515,252 in claims that would have been denied by CMS.

CONCLUSION

We understand you will need to review these findings and recommendations to determine your priorities for action. Should the State desire additional assistance with this, our contract offers eight hours of post-audit time to help you create an implementation plan.

CTI also suggests that the State perform a follow-up audit to verify that Allegiance continues to perform above benchmark, and no new processing issues occur.

We consider it a privilege to have worked for, and with, your staff and we welcome any opportunity to assist you in the future. Thank you again for choosing CTI.

CLAIM TECHNOLOGIES INCORPORATED

100 Court Avenue – Suite 306 • Des Moines, IA 50309

(515) 244-7322 • claimtechnologies.com

Comprehensive Claim Administration Audit

SPECIFIC FINDINGS REPORT

State of Montana Medical Plans

Administered by Allegiance Benefit Plan Management

Audit Period: January 1, 2020 through December 31, 2021

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CTI conducted the audit according to accepted standards and procedures for claim audits in the health insurance industry. We based our audit findings on the data and information provided by the State and Allegiance. The validity of our findings relies on the accuracy and completeness of that information. We planned and performed the audit to obtain a reasonable assurance claims were adjudicated according to the terms of the contract between Allegiance and the State.

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Audit Objectives

The objectives of CTI's audit of Allegiance's claim administration were to determine whether:

- Allegiance followed the terms of its contract with the State;
- Allegiance paid claims according to the provisions of the plan documents and if those provisions were clear and consistent;
- members were eligible and covered by the State's plans at the time a service paid by Allegiance was incurred; and
- any claim administration or eligibility maintenance systems or processes need improvement.

Audit Scope

CTI audited Allegiance's claim administration of the State medical plans for the period of January 1, 2020 through December 31, 2021. The population of claims and amount paid during that period were:

Total Paid Amount	$259,382,450
Total Number of Claims Paid/Denied/Adjusted	802,118

The audit included the following components:

1. **Operational Review and Questionnaire**
   - Claim administrator information
   - Claim administrator claim fund account
   - Claim adjudication and eligibility maintenance procedures
   - HIPAA compliance

2. **Plan Documentation Analysis**
   - Plan documents and other approved communications
   - Administrative services agreement
   - Identify missing provisions, ambiguities, and inconsistencies

3. **100% Electronic Screening with 30 Targeted Samples**
   - Systematic analysis of 100% of paid claims
   - Problem identification and quantification

4. **Random Sample Audit of 180 Claims**
   - Statistical confidence at 95% +/- 3%
   - Key Indicator performance levels
   - Benchmarking
   - Identify and prioritize problems

5. **Data Analytics**
   - Provider Discounts
   - Sanctioned Provider Identification
   - Preventive Services Payment Compliance
   - National Correct Coding Initiative Editing Compliance
   - Global Surgery Prohibited Fee Period Analysis

OPERATIONAL REVIEW

Objective

CTI's Operational Review evaluates Allegiance's claim administration systems, staffing, and procedures to identify any deficiencies that materially affect its ability to control risk and pay claims accurately on behalf of the plans.

Scope

The scope of the Operational Review included:

- Claim administrator information
  - Insurance and bonding
  - Conflicts of interest
  - Internal audit
  - Financial reporting
  - Business continuity planning
  - Claim payment system and coding protocols
  - Data and system security
  - Staffing
- Claim funding:
  - Claim funding mechanism
  - Check processing and security
  - COBRA/direct pay premium collections
- Claim adjudication, customer service, and eligibility maintenance procedures:
  - Exception claim processing
  - Eligibility maintenance and investigation
  - Overpayment recovery
  - Customer service call and inquiry handling
  - Network utilization
  - Utilization review, case management, and disease management
  - Appeals processing
- HIPAA compliance

Methodology

CTI used an Operational Review Questionnaire to gather information from Allegiance. We modeled our questionnaire after the audit tool used by certified public accounting firms when conducting an SSAE 18 audit of a service administrator. We modified that tool to elicit information specific to the administration of the State's plans.

We reviewed Allegiance's responses and any supporting documentation supplied to gain an understanding of the procedures, staffing, and systems used to administer the State's plans. This allowed us to conduct the audit more effectively.

In addition to the questionnaire, we used our proprietary Electronic Screening and Analysis System (ESAS®) software to identify the best cases to test operational processes. We selected a targeted sample

of 30 cases and provided a substantive testing questionnaire to Allegiance to collect information for each. We used the responses provided to validate that Allegiance followed procedures to control risk and accurately pay claims.

Following is a list of sample screening categories used to identify candidate cases for operational testing:

ESAS Screening Categories
Fraud, Waste, and Abuse
Subrogation/Right of Recovery from Third Party
Workers' Compensation
Coordination of Benefits
Large Claim Review
Case Management

Findings

Claim Administrator Information

CTI reviewed information about Allegiance including:

- Background information
- Financial reports
- Insurance protection types and levels
- Dedicated staffing
- Systems and software
- Fee and commission disclosure
- Performance standards
- Internal audit practices

We observed the following:

- Allegiance provided copies of its declaration pages for fidelity bond, errors and omissions, and cyber liability coverage. The pages showed the following coverage limits:

Policy	Coverage Limits
Employee Dishonesty/Crime Policy	$2,000,000 with $25,000 retention
Professional Liability Errors & Omissions	$5,000,000 with $100,000 retention
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performance specifically for the State, a best practice in contrast to administrators which report performance at a service center or book of business level.

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- Since 1999, Allegiance has used LuminX claim administration software. Allegiance also contracts with Zelis to detect claim unbundling. Allegiance has adopted most NCCI edits but some are turned off because they are incompatible with provider contracts or because they cause member inconvenience for relatively low-expense items (for example, denial of charges related to drawing blood).
- Allegiance has redundant systems at a failover location. Data is backed-up nightly and also stored at a secondary location. System file backups are maintained and rotated daily, weekly, monthly, quarterly, and annually. End of year backup tapes are retained indefinitely.
- Allegiance dedicates staff to serve the State. Senior staff all have more than 14 years of experience and a minimum of 5.5 years serving the State.
- Allegiance reported that it does not subcontract with vendors for any claim processing, member, or provider service functions for the State's account.

Claim Funding

CTI reviewed Allegiance's claim check controls and procedures for:

- Claim funding
- Fund reconciliation
- Refund and returned check handling
- Large check approval
- Security
- Stale check disposition
- Audit trail reports
- COBRA and retiree/direct pay premium collection

We observed the following:

- Allegiance issues claim checks from its own account which is also used for administrative fees. Refunds and returned checks reduce the amount of funding requests to the State.
- Allegiance has Examiner Payment/Denial Authority Levels starting for paid or denied claims at $40,000 or more. Claims of $40,001 to $74,999 must also be reviewed by an Intermediate Examiner. Claims of $75,000 to $149,999 must be reviewed by a Senior Intermediate Examiner. Finally, claims of $150,000 to $249,999 are reviewed by the Director of Technical Claim Services

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- Allegiance uses appropriate levels of security and control within its claim funding and checks issuance procedures to protect the plan's interest and ensure all transactions are performed by authorized personnel only. Checks are issued by Zelis.
- All Allegiance claim system users maintain unique access passwords. System access and override authority for its employees are based on job description.

Claim Adjudication, Customer Service, and Eligibility Maintenance Procedures

CTI reviewed Allegiance's enrollment, eligibility maintenance, and claim processing controls and procedures. We observed the following:

- Allegiance had adequately documented training, workflow, procedures, and systems to provide consistently high levels of accuracy in the processing of claims and enrollment.
- Allegiance implemented procedures for coverage of telemedicine, COVID-19 vaccines with no cost-sharing, and COVID-19 testing in compliance with the FFCA and CARES act.
- Allegiance has a dedicated IT team that loads an eligibility EDI file from the State. Allegiance's designated enrollment specialists are available to manage individual changes as necessary as well as review issues or questions and coordinate corrections with the State. Eligibility is updated daily.
- Allegiance has a State-specific procedure for determining whether dependents are disabled and still eligible to be covered by the State's plans. To be considered as disabled, members must provide Social Security documentation and tax documentation within 31 days of the date the child's coverage would be terminated as well as the member's most recent tax return which indicates the disabled child is a qualified tax dependent of the member.
- Allegiance performs Coordination of Benefits (COB) as outlined in the State's summary plan description. It provided a COB savings report for 2020 and 2021 showing $16,650,890 and $17,676,969 in savings, respectively. These amounts represent 13% of paid claims.
- 92.3% of the State's claims were submitted electronically, decreasing administrative costs and reducing the potential for manual data entry errors. However, only 55.7% of the State's claims auto-adjudicate. The lower percentage of auto adjudication is reflected in claim turnaround observed in the random sample. The median for claims turnaround is nine days with the mean turnaround at 16 days. Both measures are within norms observed by CTI.
- Allegiance performs overpayment recovery for amounts greater than $50; however, it is unable to auto-recoup overpaid amounts from a provider's next payment. It indicated it does track the reasons for overpayment, which is a best practice.
- Allegiance maintains detailed reports showing overpayments, including amounts overpaid, amounts outstanding and amounts reimbursed to the State.

Year	Requested Refunds	Amount Recovered	Outstanding Balance (as of Report Date)	Reimbursement Amount to the State	Amount Not Reimbursed to the State (as of the date of the report)
2020	$316,711.59	$243,229.66	$68,479.93	$40,523.41	$27,977.12
2021	$491,580.03	$215,162.35	$276,417.89	NA*	$242,173.54

**Allegiance will continue to collect on all outstanding amounts and final reporting will occur early in 2023.*

- Allegiance performs subrogation by pending and issuing an accident questionnaire for all claims over $1,000. Montana law requires plan participants to be made whole prior to the plan being reimbursed. As such, the State is very rarely, if ever, reimbursed through the subrogation process when member claims were caused by or contributed to by third-party liability. The State must approve any lien waivers or reductions, a best practice.
- Allegiance identifies potential Workers' Compensation claims through ICD-10 codes, provider notes, and member notification. These claims are held until an accident claim form has been completed. There must be at least $1,000 in claim payments before an investigation is undertaken.
- Allegiance's sister company, Allegiance Care Management, performs precertification and large claim management. Disease management is performed by American Health Holding.
- Allegiance keeps an internal log to track appeal timeframes and resolution. Allegiance provided 2020 and 2021 summary reports. For 2020, there were 222 appeals, 72% of which were upheld, 21% overturned, and 7% partially upheld/overturned. 98% of appeals were handled in a timely fashion in 2020. For 2021, there were 114 appeals, 74% of which were upheld, 23% overturned, and 3% partially upheld/overturned. 97% of appeals were handled in a timely fashion in 2021, although the period for resolution of the appeal is not specified.
- Allegiance's claim system does not track the date adjustments are identified; it defaults to the original claim receipt date. As a result, adjustments are excluded from claim turnaround time calculations and the corresponding performance guarantee.
- Allegiance does not have staff dedicated to detecting and investigating fraud, waste, and abuse. Allegiance's credentialing team researches past fraud and sanctions as it is credentialing providers. Zelis' code editing service provides fraud detection, as well.
- Allegiance provided a Network Savings report showing discounts of 26.6% and 29.9% for 2020 and 2021, respectively. Network utilization was high at 98.23% in 2020 and 98.24% in 2021. The State's members traveling or domiciled outside of Montana can access Cigna's OAP network which helps drive network savings.
- Allegiance compensates out-of-network providers using a fee schedule based on the percentage of Medicare used for all service reimbursements. The State's reference-based pricing network is the primary driver of network savings.

HIPAA Compliance

CTI reviewed information about the systems and processes Allegiance had in place to maintain compliance with HIPAA regulations. The objective was to determine if the administrator was aware of the HIPAA regulations and was compliant at the time of the audit. We offer the following observations from our review:

- Allegiance has appropriate levels of security and controls in place to protect the State's medical plan records and data and was compliant with HIPAA requirements at the time of the audit.
- Allegiance's Privacy Officer oversees HIPAA compliance at Allegiance.
- Allegiance employees receive online HIPAA training on an annual basis and occasionally more often.
- During the audit period, Allegiance reported it did not have any breaches triggering notification requirements for the State.

Electronic Screening and Analysis System (ESAS®) and Targeted Samples of Administrative Procedures
We used ESAS to test Allegiance's controls and procedures by selecting specific claim cases processed during the audit period. We prepared testing questionnaires (QID) for each and sent them to the administrator for completion. A CTI auditor reviewed the responses and supporting documentation.

CTI's audit did not identify any candidate cases for operational testing.

PLAN DOCUMENTATION ANALYSIS

Objective

CTI's Plan Documentation Analysis evaluates the documents governing administration of the State's medical plans and identifies inconsistencies, ambiguities, or missing provisions that might negatively impact accurate claim administration. Through this evaluation, we gained an understanding of Allegiance's administrative service responsibilities for the State's medical plans. This understanding allowed us to audit more effectively.

Scope

Our auditors evaluated:

- Plan documents, descriptions, and any amendments
- Administrative services agreement

Methodology

CTI obtained a copy of the plan documentation from the State and/or Allegiance. Our auditors reviewed the applicable documents to better understand the provisions Allegiance should have used to adjudicate all medical claims. We used a benefit matrix to help us understand the State's plan provisions. CTI's benefit matrix is a composite listing of the benefit provisions, exclusions, and limitations we expect to see in a plan document. When completed, the matrix allowed us to identify inconsistencies, ambiguities, or missing provisions.

CTI obtained clarification from the State about any inconsistencies in the plan documents. Our auditors then used the benefit matrix as a cross-reference tool as they audited claims.

Findings

Our auditors did not identify any inconsistencies, ambiguities, or missing provisions in our Plan Documentation Analysis.

100% ELECTRONIC SCREENING WITH TARGETED SAMPLE ANALYSIS

Objective

CTI's Electronic Screening and Analysis System (ESAS) software identified and quantified potential claim administration payment errors. the State and Allegiance should talk about any verified under- or overpayments to determine the appropriate actions to correct the errors.

Scope

CTI electronically screened 100% of the service lines processed by Allegiance during the audit period. The accuracy and completeness of Allegiance's data directly impacted the screening categories we completed and the integrity of our findings. We screened the following high-level ESAS categories to identify potential amounts at risk:

- Duplicate payments to providers and/or employees
- Plan exclusions and limitations
- Multiple surgical procedures

Methodology

We used ESAS to analyze claim payment accuracy as well as any opportunities for system and process improvement. Using the data file provided by Allegiance, we readjudicated each line on every claim the plan paid or denied during the audit period against the plan's benefits. Our Technical Lead Auditor tested a targeted sample of claims to provide insight into Allegiance's claim administration as well as operational policies and procedures. We followed these procedures to complete our ESAS process:

- ***Electronic Screening Parameters Set*** – We used the State's plan document provisions to set the parameters in ESAS.
- ***Data Conversion*** – We converted and validated the State's claim data, reconciled it against control totals, and checked it for reasonableness.
- ***Electronic Screening*** – We systematically screened 100% of the service lines processed and flagged claims not administered according to plan parameters.
- ***Auditor Analysis*** – If claims within an ESAS screening category represented a material amount, our auditors analyzed the findings to confirm results were valid. When using ESAS to identify payment errors, note that incomplete claim data could lead to false positives. CTI auditors made every effort to identify and remove false positives.
- ***Targeted Sample Analysis*** – From the categories identified with material amounts at risk, we selected the best examples of potential under- or overpayments to test. As cases were not randomly selected, we cannot extrapolate results. We selected a total of 30 cases and sent Allegiance a questionnaire for each. Targeted samples verified if the claim data supported our finding and if our understanding of plan provisions matched Allegiance's administration.
- ***Audit of Administrator Response and Documentation*** – We reviewed the responses and redacted the responses to eliminate personal health information. Based on the responses and further analysis of the findings, we removed false positives identified from the potential amounts at risk.

Findings

Additional Observations

During the ESAS review, our auditor observed the following procedures or situations that may not have caused an error on the sampled claim but may impact future claims or overall quality of service.

Observation	QID Number
When this claim was manually processed on 6/24/21, the pricing was verified and priced as in-network, allowing 100% and was determined to be correct. Based on this, a payment of $137,686.40 was issued on 7/2/21. An inquiry on 8/5/21 indicated the claim appeared to have been billed incorrectly so on 8/19/21 a full refund was requested. Then, on 9/22/21 an examiner reviewed the corrected claim received and an overpayment of $99,358.40 was identified and on 9/23/21 a refund request was sent for $99,358.40. When no response was received, a second request was faxed by the recovery team on 10/22/21. As of the date of this report, the refund of $99,358.40 had not yet been received.	17

RANDOM SAMPLE AUDIT

Objectives

The objectives of our Random Sample Audit were to determine if claims were paid according to plan specifications and the administrative agreement, to measure and benchmark process quality, and to prioritize areas of administrative deficiency for further review and remediation.

Scope

CTI's Random Sample Audit included a stratified random sample of 180 paid or denied claims. The statistical confidence level of the audit sample was 95%, with a 3% margin of error. A copy of the Sample Construction and Weighting Methodology Report for the sample is in Appendix A.

Allegiance's performance was measured using the following key performance indicators:

- Financial Accuracy
- Accurate Payment
- Accurate Processing

We also measured claim turnaround time, a commonly relied upon performance measure.

Methodology

Our Random Sample Audit ensures a high degree of consistency in methodology and is based upon the principles of statistical process control with a management philosophy of continuous quality improvement. Our auditors reviewed each sample claim selected to ensure it conformed to plan specifications, agreements, and negotiated discounts. We recorded our findings in our proprietary audit system.

When applicable, we cited claim payment and processing errors identified by comparing the way a selected claim was paid and the information Allegiance had available at the time the transaction was processed**. It is important to note that even if the sampled claim was subsequently corrected prior to CTI's audit, we have still cited the error so you can discuss how to reduce errors and re-work in the future with the State's administrator.**

CTI communicated with Allegiance in writing about any errors or observations using system-generated response forms. We sent Allegiance a preliminary report for its review and written response. We considered Allegiance's written response, as found in Appendix B, when producing our final reports.

Findings

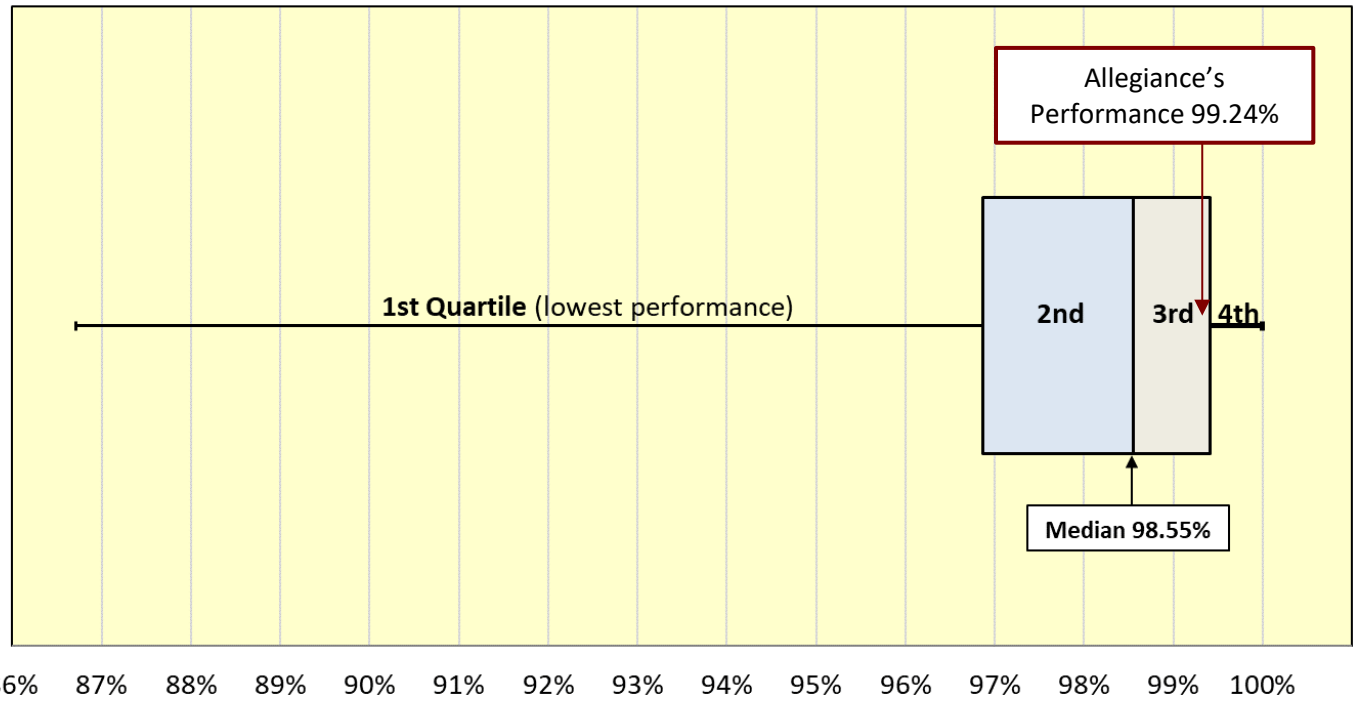
The following box and whiskers charts demonstrate Allegiance's performance as compared to the last 100 medical audits performed by CTI. The fourth quartile represents the 25 highest performing plans, and the first quartile represents the lowest 25. The Median is the point at which 50 plans audited were above, and 50 plans were below.

Financial Accuracy

CTI defines Financial Accuracy as the total correct claim payments made compared to the total dollars of correct claim payments that should have been made for the audit sample.

The claims sampled and reviewed revealed $150.00 in underpayments and $135.07 in overpayments, for a combined variance of $285.07. The correct payment total for the adequately documented claims in the audit sample should have been $933,122.76.

The weighted Financial Accuracy rate was 99.24%.



Financial Accuracy and Accurate Payment Detail Report					
Error Description	**Audit No.**	**Under/ Over Paid**	**Allegiance Response**	**CTI Conclusion**	**Manual or System**
Denied Eligible Procedure	1009	$150.00	Agree to disagree. Claim paid 11.2.20, call from provider, claim review and reprocessing all took place 11.17.2020 with payment of $150.00 being issued 11.30.20. The misread of the EOB was not initially identified for correction by CTI during audit. The issue was identified and immediately corrected 1.5 years ago.	Procedural error and underpayment remain due to denial of an eligible expense. At time the claim was initially processed, it was processed incorrectly. CTI acknowledges the claim was later corrected. Per page eight of the State of MT Scope and Methodology 2021 10 22.pdf document shared with Allegiance on 10/27/21, *It is important to note that even if the sampled claim was subsequently corrected prior to CTI's audit, we will still cite the error so Allegiance and the State can discuss how to reduce errors and re-work in the future.*	☒ M ☐ S
Subtotal	**1**				
Coordination of Benefits	1147	$102.53	Agree. Dependent child at time of service was 20 years old. The court order remains in place for the younger children. When	Procedural error and overpayment remain as agreed.	☐ M ☒ S

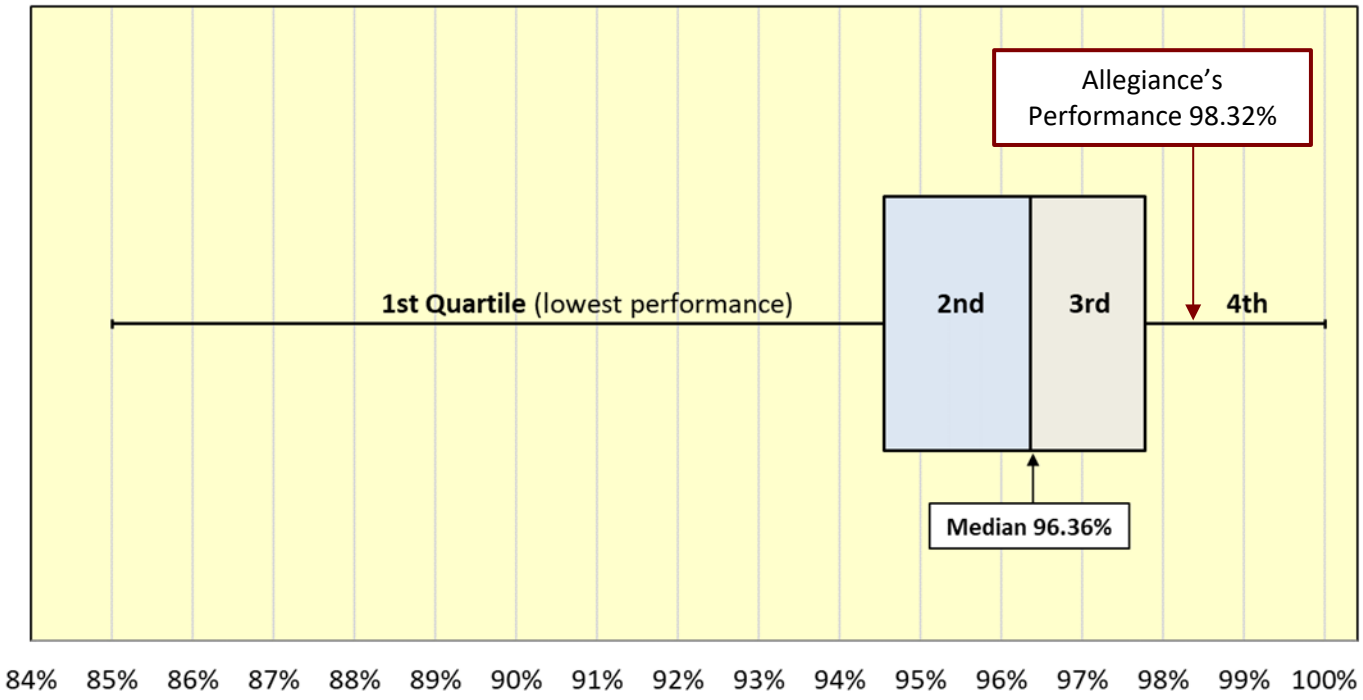
Financial Accuracy and Accurate Payment Detail Report						
Error Description	**Audit No.**	**Under/ Over Paid**	**Allegiance Response**	**CTI Conclusion**	**Manual or System**	
			parents are divorced and the dependent is 18+ years old a divorce decree no longer applies. The only rule that applies in this situation is longer/shorter rule, determined as result of COB investigation. Per COBQ received Anthem plan has been effective since 10/01/08 and per court decree would have been primary on the dependent from time of divorce through the 18th birthday, dependent was added to the plan to the SOM plan 5.30.17. DOB is below. Claim processed prior to set up of "generic" COB screen to stop processing/auto release function.			
Subtotal	**1**					
Paid Ineligible Procedure	1136	$32.54	Agree. Following review, code Q3014 not eligible as submitted on claim XXXXXXXXACP9.	Procedural error and overpayment remain due to payment of an ineligible expense.	☒ M ☐ S	
Subtotal	**1**					
TOTALS	**3**	**VARIANCE $285.07**			**M: 2**	**S: 1**

Accurate Payment

CTI defines Accurate Payment as the number of claims paid correctly compared to the total number of claims paid for the audit sample.

The audit sample revealed 3 incorrectly paid claims and 176 correctly paid claims. Note CTI only uses adequately documented claims for this calculation.

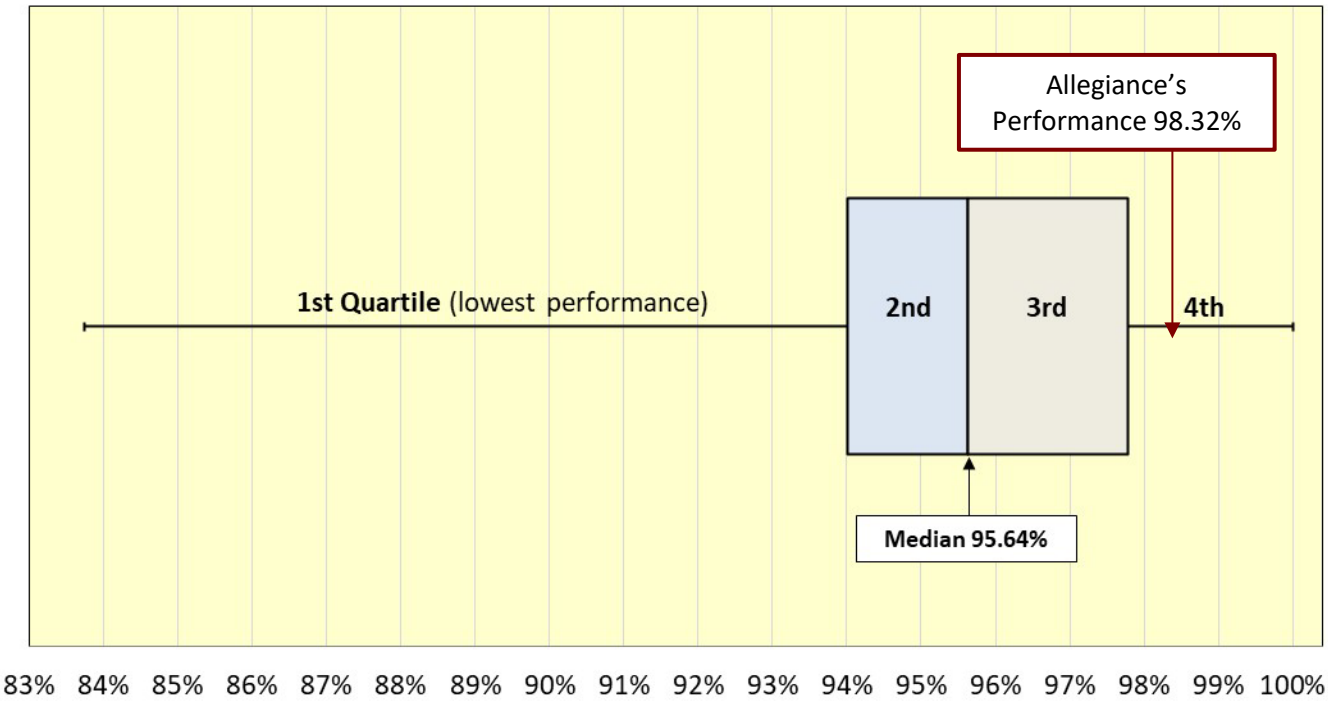
Total Claims	Incorrectly Paid Claims		Frequency
	Underpaid Claims	Overpaid Claims	
180	1	2	98.32%



Accurate Processing

CTI defines Accurate Processing as the number of claims processed without errors compared to the total number of claims processed in the audit sample. When a claim had errors that applied in more than one category, it was counted only once as a single incorrect claim for this measure.

Correctly Processed Claims	Incorrectly Processed Claims		Frequency
	System	Manual	
176	1	2	98.32%



Accurate Processing Detail Report				
Error Description	**Audit No.**	**Allegiance Response**	**CTI Conclusion**	**Manual or System**
Coordination of Benefits				
COB Adjudication	1147	Agree. Dependent child at time of service was 20 years old. The court order remains in place for the younger children. When parents are divorced and the dependent is 18+ years old a divorce decree no longer applies. The only rule that applies in this situation is longer/ shorter rule, determined as result of COB investigation. Per COBQ received Anthem plan has been effective since 10/01/08 and per court decree would have been primary on the dependent from time of divorce through the 18th birthday, dependent was added to the plan to the SOM plan 5.30.17. DOB is below. Claim processed prior to set up of "generic" COB screen to stop processing/ auto release function.	Procedural error remains as agreed.	☐ M ☒ S

Accurate Processing Detail Report				
Error Description	**Audit No.**	**Allegiance Response**	**CTI Conclusion**	**Manual or System**
Policy Provision				
Denied Eligible Procedure	1009	Agree to disagree. Claim paid 11.2.20, call from provider, claim review and reprocessing all took place 11.17.2020 with payment of $150.00 being issued 11.30.20. The misread of the EOB was not initially identified for correction by CTI during audit. The issue was identified and immediately corrected 1.5 years ago.	Procedural error remains due to denial of an eligible expense. At time the claim was initially processed, it was processed incorrectly. CTI acknowledges the claim was later corrected. Per page eight of the State of MT Scope and Methodology 2021 10 22.pdf document shared with Allegiance on 10/27/21, *It is important to note that even if the sampled claim was subsequently corrected prior to CTI's audit, we will still cite the error so Allegiance and the State can discuss how to reduce errors and re-work in the future.*	☒ M ☐ S
Paid Ineligible Procedure	1136	Agree. Following review, code Q3014 not eligible as submitted on claim XXXXXXXXACP9.	Procedural error remains as agreed.	☒ M ☐ S

Claim Turnaround

CTI defines Claim Turnaround as the number of calendar days required to process a claim – from the date the claim was received by the administrator to the date a payment, denial, or additional information request was processed – expressed as both the Median and Mean for the audit sample.

Claim administrators commonly measure claim turnaround time in mean days. Median days, however, is a more meaningful measure for administrators to focus on when analyzing claim turnaround because it prevents one or just a few claims with extended turnaround time from distorting the true performance picture.

Median	Mean	+45 Days to Process
9	16	9

DATA ANALYTICS

This component of our audit used the State's electronic claim data to identify improvement opportunities and potential recoveries. The informational categories we analyzed include:

- Network Provider Utilization and Discount Savings;
- Sanctioned Provider Identification;
- Patient Protection and Affordable Care Act (PPACA) Preventive Services Payment Compliance;
- National Correct Coding Initiative (NCCI) Editing Compliance; and
- Global Surgery Prohibited Fee Period Analysis.

The following pages provide the scope and report for each data analytic to enable more-informed decisions about ways the State can maximize benefit plan administration and performance.

Network Provider Utilization and Discount Savings

The Network Provider Utilization and Discount Savings report provides an evaluation of provider network discounts obtained during the audit period. Since discounts can be calculated differently by administrators, carriers, and benefit consultants, we believe calculating discounts in the same manner for all our clients will allow for more meaningful comparisons to be made.

Scope

CTI compared submitted charges to allowable charges for all claims paid during the audit period. The review was divided into three subsets:

- In-network
- Out-of-network
- Secondary networks

Each of these subsets was further delineated into four subgroups:

- Ancillary services
- Non-facility services
- Facility inpatient
- Facility outpatient

Report

The following report relied on the data and data fields provided by Allegiance. We made no assumptions when requested data fields were not provided.

Paid Dates 1/1/2020 through 12/31/2021				
Proprietary and Confidential Information. Do not reproduce without express permission of Claim Technologies Inc.				
Total of All Claims				
Claim Type	**Allowed Amount**	**Provider Discount**		**Paid**
Ancillary	$12,876,932	$5,747,634	30.9%	$10,824,667
Non-Facility	$99,641,683	$44,837,090	31.0%	$78,336,567
Facility Inpatient	$57,855,693	$20,055,539	25.7%	$54,396,171
Facility Outpatient	$105,172,616	$41,853,892	28.5%	$86,645,117
Total	**$275,546,923**	**$112,494,154**	**29.0%**	**$230,202,523**
In-Network				
Claim Type	**Allowed Amount**	**Provider Discount**		**Paid**
Ancillary	$12,153,975	$5,747,634	32.1%	$10,285,584
Non-Facility	$98,336,574	$44,837,090	31.3%	$77,833,383
Facility Inpatient	$57,624,287	$20,055,539	25.8%	$54,334,523
Facility Outpatient	$104,484,257	$41,853,892	28.6%	$86,412,829
Total In-Network	**$272,599,092**	**$112,494,154**	**29.2%**	**$228,866,319**
% of Eligible Charge -	98.9%	% Claim Frequency -	93.0%	
Out of Network				
Claim Type	**Allowed Amount**	**Provider Discount**		**Paid**
Ancillary	$722,957	$0	0.0%	$539,083
Non-Facility	$1,305,109	$0	0.0%	$503,184
Facility Inpatient	$231,406	$0	0.0%	$61,648
Facility Outpatient	$688,359	$0	0.0%	$232,288
Total Out of Network	**$2,947,830**	**$0**	**0.0%**	**$1,336,203**
% of Eligible Charge -	1.1%	% Claim Frequency -	7.0%	

**Paid claim totals exclude claims from members aged 65 and older.*

The State's members had utilization of network or secondary network providers at 98.9% of all allowed charges and 93.0% of all claims.

Sanctioned Provider Identification

The Sanctioned Provider Identification report identifies services rendered by providers on the Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE). OIG's LEIE provides information to the healthcare industry, patients, and the public about individuals and entities currently excluded from participation in Medicare, Medicaid, and all other federal health care programs.

Scope

We received and converted an electronic data file of all claims processed during the audit period. The claims screened included all medical (not including prescription drug) claims paid or denied during the audit period. Through electronic screening, we identified all claims in the audit universe that were non-facility claims, i.e., claims submitted by providers of service other than hospitals, nursing, or skilled care facilities, or durable medical equipment suppliers. These claims include physician and other medical professional claims.

Report

We screened 100% of non-facility claims against OIG's LEIE and there were no claims paid to providers on the OIG's LEIE.

PPACA Preventive Services Coverage Compliance

The Preventive Services Coverage Compliance report confirms that the administrator processed preventive services as required by PPACA and as regulated by the Department of Health and Human Services (HHS). The federal PPACA mandate for all health plans (unless grandfathered) requires that certain preventive services, if performed by a network provider, must be covered at 100% without copayment, coinsurance, or deductible. Our review analyzed in-network preventive care services to determine if Allegiance paid services in compliance with PPACA guidelines.

Scope

Our review included all in-network services we believe should be categorized as preventive and paid at 100%. The guidance provided by HHS for the definition of preventive services is somewhat vague, leaving it up to individual health plans to define their own system edits. In addition to the U.S. Preventive Services Task Force recommendations, CTI researched best practices of major health plan administrators to develop a compliance review we believe reflects the industry's most comprehensive overview of procedures to be paid at 100%.

Our review did not include services:

- performed by an out-of-network provider;
- adjusted or paid more than once (duplicate payments) during the audit period; or
- for which PPACA requirements suggest a frequency limitation such as one per year.

Our data analytics parameters relied upon the published recommendations from the sources HHS used to create the list of preventive services for which it has mandated coverage.

Report

We analyzed the payments to determine if they were compliant. Types of services for which we identified non-compliance (if any) are listed first and the percentage of allowed charge paid is in the last column. To demonstrate full compliance with PPACA's requirements, the last column of this report should show 100% of services performed by network providers were paid and that no deductible, coinsurance, or copayment was applied.

Because services may be denied for reasons other than exclusion or limitation of non-covered services (e.g., a service could be denied because the patient was ineligible at the time it was performed), less than 100% of the preventive services may be paid.

The preventive services compliance review shows the frequency of claims paid at less than required benefit levels (i.e., claims reduced payment due to the application of deductibles, coinsurance, and/or copayments). We electronically screened 78 categories of preventive services that match the preventive care services specified by HHS including immunizations, women's health, tobacco use counseling, cholesterol and cancer screenings, and wellness examinations. This review either confirms compliance with PPACA or highlights areas for improvement.

CTI's analysis also found that 94.82% of the procedure codes identified as preventive services were paid by Allegiance at 100% when provided in-network. A detailed list of the other 5.18% is available upon request.

The following report provides an outline for discussion between the State and Allegiance.

Preventive Care Services Compliance Review												
State of Montana - Allegiance Benefit Plan Management												
Audit Period 1/1/2020 - 12/31/2021												
Plans: All												
Filters: Exclude - out of network, adjustments, edits with frequency limits, claimants 65 or older												
		Claim Lines Submitted	Denied	Applied Deductible		Applied Copay		Applied Coinsurance		Paid @100%		
Edit Guideline	Preventive Service Benefit	#	#	#	Amount	#	Amount	#	Amount	#	Amount	%
HHS	Gestational Diabetes Mellitus screening - women	1,248	36	567	$10,511	0	$0	537	$2,786	108	$1,677	8.91%
Bright Futures	Hearing Screening 0-21 yrs	353	4	300	$3,727	1	$24	10	$25	38	$4,678	10.89%
USPSTF-A,B	Rh incompatibility screening - pregnant women	610	30	274	$8,447	0	$0	171	$1,748	135	$2,313	23.28%
USPSTF-A	Ambulatory blood pressure screening - adult	4	0	1	$77	0	$0	2	$38	1	$77	25.00%
USPSTF-A	Hepatitis B screening - women	380	16	182	$4,103	0	$0	82	$698	100	$1,737	27.47%
USPSTF-A	HIV screening - pregnant women	397	12	180	$6,344	0	$0	68	$1,034	137	$3,949	35.58%
USPSTF-A	Syphilis screening - pregnant women	196	5	65	$1,582	0	$0	50	$404	76	$1,484	39.79%
USPSTF-A	Urinary tract infection screening - pregnant women	475	8	151	$4,608	0	$0	110	$1,057	206	$3,305	44.11%
USPSTF-B	Breast cancer chemoprevention counseling- >17	35	1	1	$398	12	$330	1	$38	20	$4,191	58.82%
USPSTF-B	Depression screening - 12-18	49	2	11	$89	0	$0	1	$2	35	$331	74.47%
USPSTF-A	Hypothyroidism screening - 0-90 days	10	0	0	$0	0	$0	2	$13	8	$189	80.00%
USPSTF-B	Gonorrhea screening - female	981	15	86	$6,272	0	$0	80	$1,593	800	$49,476	82.82%
ACIP	Immunizations - Pneumococcal <19	6	0	0	$0	0	$0	1	$29	5	$658	83.33%
USPSTF-A,B	Chlamydia infection screening - women	1,030	14	92	$7,183	0	$0	72	$1,475	852	$52,887	83.86%
USPSTF-B	Hearing loss screening - 0 - 90 days	46	1	4	$389	0	$0	3	$98	38	$5,907	84.44%
USPSTF-B	Depression screening - >18	191	8	20	$192	0	$0	4	$8	159	$2,324	86.89%
ACIP	Immunizations - Pneumococcal >18	226	9	8	$1,399	0	$0	11	$493	198	$28,436	91.24%
USPSTF-B	Hepatitis C Virus (HCV) Screening	563	26	23	$871	0	$0	23	$227	491	$21,777	91.43%
USPSTF-A	Phenylketonuria (PKU) screening 0-90 days	39	1	3	$284	0	$0	0	$0	35	$1,513	92.11%
HHS	Breastfeeding support and counseling - women	507	34	5	$389	4	$100	28	$665	436	$52,772	92.18%
HHS	Contraceptive methods - women	2,419	35	153	$4,473	0	$0	30	$559	2,201	$697,272	92.32%
HHS	Wellness Examinations - >18	2,653	36	80	$13,414	74	$1,910	34	$1,127	2,429	$490,895	92.82%
USPSTF-B	Alcohol misuse - screening and counseling	63	2	1	$43	1	$25	2	$23	57	$2,121	93.44%
Bright Futures	Lead screening - <21	207	2	10	$190	0	$0	2	$10	193	$3,874	94.15%
ACIP	Immunizations - Herpes Zoster >59	749	7	14	$2,768	0	$0	23	$1,341	705	$126,822	95.01%
USPSTF-B	Healthy diet counseling	186	11	0	$0	7	$185	1	$40	167	$20,189	95.43%
USPSTF-B	BRCA screening counseling - women	103	12	1	$117	2	$50	0	$0	88	$45,058	96.70%
HHS	Wellness Examinations - women	6,374	70	20	$3,234	174	$4,370	7	$307	6,103	$1,274,901	96.81%
ACIP	Immunizations - Influenza Age >18	3,671	36	48	$1,888	0	$0	59	$560	3,528	$80,906	97.06%
USPSTF-A	Syphillis screening	39	3	0	$0	0	$0	1	$3	35	$918	97.22%
ACIP	Immunization Administration - >18	9,901	145	125	$7,412	0	$0	133	$2,546	9,498	$303,800	97.36%
ACIP	Immunizations - Hepatitis B >18	107	2	0	$0	0	$0	2	$28	103	$8,644	98.10%
USPSTF-A	Colorectal cancer screening - 45-75	1,949	71	7	$2,253	0	$0	10	$1,498	1,861	$1,340,339	99.09%
ACIP	Immunizations - Hepatitis A >18	133	2	0	$0	0	$0	1	$30	130	$10,246	99.24%
HRSA/HHS	Wellness Examinations - <19	7,814	61	9	$1,031	31	$775	0	$0	7,713	$1,378,116	99.48%
Bright Futures	Iron Supplement - <21	452	7	2	$7	0	$0	0	$0	443	$1,773	99.55%
ACIP	Immunizations - DTP <19	2,533	10	3	$206	0	$0	5	$119	2,515	$180,161	99.68%
ACIP	Immunizations - Meningococcal <19	719	4	0	$0	0	$0	2	$90	713	$101,206	99.72%
USPSTF-A	HIV screening - >14	392	13	1	$119	0	$0	0	$0	378	$14,624	99.74%
ACIP	Immunizations - Meningococcal >18	414	9	0	$0	0	$0	1	$80	404	$87,727	99.75%
ACIP	Immunization Administration - <19	9,814	63	13	$231	0	$0	9	$79	9,729	$391,229	99.77%
ACIP	Immunizations - Influenza <19	3,623	22	2	$46	0	$0	6	$34	3,593	$79,873	99.78%
USPSTF-A	Cervical Cancer Screening (Pap) - women	3,358	76	6	$445	0	$0	1	$13	3,275	$167,918	99.79%
ACIP	Immunizations - Human papillomavirus	1,006	9	2	$350	0	$0	0	$0	995	$288,482	99.80%
USPSTF-A	Cholesterol abnormalities screening - men 35-75	1,448	16	2	$223	0	$0	0	$0	1,430	$44,456	99.86%
HHS	Cervical Cancer Screening (HPV DNA) - women >29	1,622	31	2	$189	0	$0	0	$0	1,589	$112,548	99.87%
USPSTF-B	Breast cancer mammography screening - >39	10,748	67	6	$1,384	0	$0	5	$579	10,670	$1,333,225	99.90%
USPSTF-A,B	Cholesterol abnormalities screening - women >19	1,034	14	0	$0	0	$0	0	$0	1,020	$39,963	100.00%
ACIP	Immunizations - Rotavirus <19	930	3	0	$0	0	$0	0	$0	927	$89,823	100.00%
ACIP	Immunizations - Hepatitis A <19	924	4	0	$0	0	$0	0	$0	920	$39,211	100.00%
Bright Futures	Developmental Autism screening - <3	696	3	0	$0	0	$0	0	$0	693	$11,895	100.00%
ACIP	Immunizations - Varicella <19	540	3	0	$0	0	$0	0	$0	537	$52,605	100.00%
FDA/CDC	Immunizations - Covid19	345	2	0	$0	0	$0	0	$0	343	$10,171	100.00%
USPSTF-B	Vision screening - 3- 5	341	1	0	$0	0	$0	0	$0	340	$2,574	100.00%
ACIP	Immunizations - Measles, Mumps, Rubella <19	334	4	0	$0	0	$0	0	$0	330	$69,910	100.00%
Bright Futures	Dyslipidemia screening - 2-20	282	11	0	$0	0	$0	0	$0	271	$5,641	100.00%
ACIP	Immunizations - Hepatitis B <19	112	0	0	$0	0	$0	0	$0	112	$3,588	100.00%
USPSTF-B	Tobacco use counseling - >18	80	3	0	$0	0	$0	0	$0	77	$2,119	100.00%
Bright Futures	Tuberculin testing - <21	55	1	0	$0	0	$0	0	$0	54	$751	100.00%
ACIP	Immunizations - Inactivated Poliovirus <19	52	0	0	$0	0	$0	0	$0	52	$2,116	100.00%
ACIP	Immunizations - Varicella >18	19	0	0	$0	0	$0	0	$0	19	$1,866	100.00%
USPSTF-A	Hemoglobinopathies or sickle cell screening 0-90 days	8	0	0	$0	0	$0	0	$0	8	$215	100.00%
ACIP	Immunizations adult - Influenza Age (FluMist) 19-49	5	0	0	$0	0	$0	0	$0	5	$117	100.00%
USPSTF-B	Tobacco use counseling - <19	4	1	0	$0	0	$0	0	$0	3	$91	100.00%
ACIP	Immunizations - DTP >18	1	0	0	$0	0	$0	0	$0	1	$34	100.00%
USPSTF-B	Pre-Diabetes/Type 2 Diabetes	1	0	0	$0	0	$0	0	$0	1	$345	100.00%
	Totals	**85,606**	**1,094**	**2,480**	**$96,887**	**306**	**$7,769**	**1,590**	**$21,498**	**80,136**	**$9,160,040**	**94.82%**

PPACA Preventive Services Coverage Compliance Detail Report				
QID	**Error Description**	**Under/ Over Paid**	**Allegiance Response**	**CTI Conclusion**
6	Deductible Applied	$995.41	Agree. Manual override routine service was missed. Claim was billed with a REV code of 490 for AMB SC when processed manual override would need to be entered to allow to the colonoscopy benefit. The claim has been reprocessed to allow additional payment in amount of $995.41. Manually adjudicated.	Procedural deficiency and underpayment remain. Deductible was incorrectly applied to this preventive service.

NCCI Editing Compliance

While there are no universally accepted correct coding guidelines among private insurers and administrators, the Centers for Medicare & Medicaid Services (CMS), the nation's largest payer for health care, took the initiative to provide valuable guidance for medical benefit plans. Implementation of NCCI mandated several initiatives to prevent improperly billed claims from being paid under Medicare and Medicaid.

Scope

The two NCCI initiatives that can offer the greatest return benefit to self-funded employee benefit plans are the Procedure-to-Procedure (PTP) Edits and Medically Unlikely Edits (MUEs).

Our claim system code editing analysis identified services submitted to the plan and paid by Allegiance that Medicare and Medicaid would have denied. Since Allegiance paid the billed charges, the payments represent a potential savings opportunity to the State.

It is difficult to establish the extent to which administrators and carriers use NCCI edits; however, CTI recommends these reports be discussed with administrators to determine the extent they could incorporate CMS edits. Using these edits typically reduces claim expenses for employers and their employees, as well as furthering efforts toward achieving standardized code-editing systems for all payers.

PTP Edits Report

PTP Edits compare procedure codes from multiple claim lines on the same day to identify when procedures submitted on the same claim cannot be billed together. Our reports are grouped by outpatient hospital services and non-facility claims using CMS's quarterly updated data. If Allegiance is not currently using these CMS edits, CTI's reports will help you evaluate the savings you would have realized had the PTP Edits been in place.

The following table shows procedures which were allowed by Allegiance that would have been denied had the CMS edits be used.

Procedure to Procedure Edits								
State of Montana - Allegiance Benefit Plan Management Based on Paid Dates 1/1/2020 through 12/31/2021								
Outpatient Hospital Services (facility claims with codes not designated inpatient)								
Primary		**Secondary**		**Mod**	**Primary Description**	**Secondary Description**	**Line**	**Secondary**
Code	**Mod**	**Code**	**Mod**	**Use**			**Count**	**Allowable Benefit**
78830		C2616		YES	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharma agent	BRACHYTX, NON-STR,YTTRIUM-90	1	$23,423
					Misuse of column two code with column one code			
23660		23615		YES	TREAT SHOULDER DISLOCATION	TREAT HUMERUS FRACTURE	1	$23,087
					HCPCS/CPT procedure code definition			
45385	PT	45380	PT	YES	LESION REMOVAL COLONOSCOPY	COLONOSCOPY AND BIOPSY	26	$18,593
					More extensive procedure			
52441		C9739		YES	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant	Cystourethroscopy, with insertion of transprostatic implant; 1 to 3 implants	1	$11,476
					Mutually exclusive procedures			
28309		28306		YES	INCISION OF METATARSALS	INCISION OF METATARSAL	1	$7,830
					HCPCS/CPT procedure code definition			
C9600		93454		YES	Percutaneous transcatheter placement of drug eluting intracoronary stent(s)	CORONARY ARTERY ANGIO S&I	1	$7,506
					CPT Manual or CMS manual coding instructions			
28120		27625		YES	PART REMOVAL OF ANKLE/HEEL	REMOVE ANKLE JOINT LINING	1	$7,127
					Standards of medical / surgical practice			
74177		96374		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG INJ IV PUSH	51	$7,002
					Standards of medical / surgical practice			
99219		99285		YES	INITIAL OBSERVATION CARE	EMERGENCY DEPT VISIT	6	$6,090
					CPT Manual or CMS manual coding instructions			
29898	SG	27635	SG	YES	ANKLE ARTHROSCOPY/SURGERY	REMOVE LOWER LEG BONE LESION	2	$5,967
					Misuse of column two code with column one code			
						Top 10 TOTAL	**91**	**$118,101**
						GRAND TOTAL	**1,867**	**$433,903**

Non-Facility (non-facility claims with CPT codes:00100 - 99999)								
Primary		**Secondary**		**Mod**	**Primary Description**	**Secondary Description**	**Line**	**Secondary**
Code	**Mod**	**Code**	**Mod**	**Use**			**Count**	**Allowable Benefit**
90471		99213		YES	IMMUNIZATION ADMIN	Office/outpatient visit for E&M of estab patient, 20-29 min total time spent on date of encounter.	16	$1,798
					CPT Manual or CMS manual coding instructions			
90471		99214		YES	IMMUNIZATION ADMIN	Office/outpatient visit for E&M of estab patient, 30-39 min total time spent on date of encounter.	10	$1,764
					CPT Manual or CMS manual coding instructions			
90471		99215		YES	IMMUNIZATION ADMIN	Office/outpatient visit for E&M of estab patient, 40-54 min total time spent on date of encounter.	5	$1,317
					CPT Manual or CMS manual coding instructions			
63042	LT	69990		NO	LAMINOTOMY SINGLE LUMBAR	MICROSURGERY ADD-ON	1	$1,287
					Misuse of column two code with column one code			
98941		97140		YES	Chiropract manj 3-4 regions	Manual therapy 1/> regions	44	$1,262
					Standards of medical / surgical practice			
22633	22	63047	22	YES	LUMBAR SPINE FUSION COMBINED	Remove spine lamina 1 lmbr	1	$935
					Misuse of column two code with column one code			
88360		88341		YES	TUMOR IMMUNOHISTOCHEM/MANUAL	Immunohistochemistry or immunocytochemistry, per specimen; each additional single antibody stain pro	1	$926
					CPT Manual or CMS manual coding instructions			
31500		99291		YES	INSERT EMERGENCY AIRWAY	CRITICAL CARE FIRST HOUR	1	$915
					CPT Manual or CMS manual coding instructions			
75716	26	36005	50,51	YES	ARTERY X-RAYS ARMS/LEGS	INJECTION EXT VENOGRAPHY	1	$786
					Misuse of column two code with column one code			
96372		99213		YES	THER/PROPH/DIAG INJ SC/IM	Office/outpatient visit for E&M of estab patient, 20-29 min total time spent on date of encounter.	7	$780
					Standards of medical / surgical practice			
						Top 10 TOTAL	**87**	**$11,769**
						GRAND TOTAL	**531**	**$36,811**

MUE Report

An MUE is an edit that tests claim lines for the same beneficiary, procedure code, date of service, and billing provider against a maximum allowable number of service units. The MUE rule for a given code is the maximum number of service units a provider should report for a single day of service. MUE errors could be caused by incorrect coding, inappropriate services performed, or fraud. MUEs do not require Medicare contractors to perform a manual review or suspend claims; rather, claim lines are denied and must be correctly resubmitted by providers, typically with a lesser payment amount.

CTI's MUE analyses are grouped into three separate reports:

- Outpatient hospital
- Non-facility
- Ancillary

The following table shows procedures which were allowed by Allegiance that would have been denied had the CMS edits be used.

NCCI MUE Edits				
State of Montana - Allegiance Benefit Plan Management Based on Paid Dates 1/1/2020 through 12/31/2021				
Outpatient Hospital Services (facility claims with codes not designated inpatient)				
Procedure Code	**Service Unit Limit**	**Procedure Description**	**Line Count Exceeding Limit**	**Gross Benefit Allowed**
77301	1	RADIOTHERAPY DOSE PLAN IMRT	10	$35,124
		Rationale: Nature of Service/Procedure		
99217	2	OBSERVATION CARE DISCHARGE	94	$24,642
		Rationale: Code Descriptor / CPT Instruction		
80307	1	DRUG TEST PRSMV INSTRMNT CHEMISTRY ANALYZERS	56	$18,425
		Rationale: Code Descriptor / CPT Instruction		
90999	1	DIALYSIS PROCEDURE	19	$15,748
		Rationale: Clinical: CMS Workgroup		
99220	1	INITIAL OBSERVATION CARE	51	$15,490
		Rationale: Code Descriptor / CPT Instruction		
99219	1	INITIAL OBSERVATION CARE	40	$15,174
		Rationale: Code Descriptor / CPT Instruction		
J2710	10	NEOSTIGMINE METHYLSLFTE INJ	69	$14,232
		Rationale: Clinical: Data		
C9739	1	Cystourethroscopy, with insertion of transprostatic implant; 1 to 3 implants	1	$11,476
		Rationale: Code Descriptor / CPT Instruction		
77290	1	SET RADIATION THERAPY FIELD	11	$11,176
		Rationale: Nature of Service/Procedure		
77470	1	SPECIAL RADIATION TREATMENT	6	$9,761
		Rationale: Code Descriptor / CPT Instruction		
		Top 10 TOTAL	**357**	**$171,248**
		GRAND TOTAL	**1,014**	**$445,041**

Non-Facility (non-facility claims with CPT codes:00100 - 99999)				
Procedure Code	**Service Unit Limit**	**Procedure Description**	**Line Count Exceeding Limit**	**Gross Benefit Allowed**
J1301	60	INJECTION, EDARAVONE, 1 MG	20	$267,809
		Rationale: Prescribing Information		
95165	30	ANTIGEN THERAPY SERVICES	18	$18,373
		Rationale: Clinical: Data		
30117	2	REMOVAL OF INTRANASAL LESION	2	$9,156
		Rationale: Clinical: Data		
A0425	250	GROUND MILEAGE	1	$9,087
		Rationale: Clinical: Data		
96133	7	NEUROPSYCHOLOGICAL TST EVAL PHYS/QHP EA ADDL HR	5	$7,805
		Rationale: Nature of Service/Procedure		
97153	32	ADAPTIVE BEHAVIOR TX BY PROTOCOL TECH EA 15 MIN	21	$6,527
		Rationale: Clinical: Society Comment		
36226	1	Place cath vertebral art	2	$6,094
		Rationale: CMS Policy		
97811	2	ACUPUNCT W/O STIMUL ADDL 15M	62	$5,338
		Rationale: Nature of Service/Procedure		
36224	1	Place cath carotd art	1	$5,243
		Rationale: CMS Policy		
86255	5	FLUORESCENT ANTIBODY SCREEN	3	$5,224
		Rationale: Clinical: Data		
		Top 10 TOTAL	**135**	**$340,655**
		GRAND TOTAL	**381**	**$385,447**

Ancillary (All other claims not flagged Inpatient, Outpatient Hospital, or non-facility)				
Procedure Code	**Service Unit Limit**	**Procedure Description**	**Line Count Exceeding Limit**	**Gross Benefit Allowed**
K0553	1	THER CGM SUPPLY ALLOWANCE	83	$120,369
		Rationale: Code Descriptor / CPT Instruction		
J1555	1500	Injection, immune globulin (cuvitru), 100 mg	1	$42,161
		Rationale: Clinical: CMS Workgroup		
A4253	1	BLOOD GLUCOSE/REAGENT STRIPS	524	$14,852
		Rationale: Nature of Equipment		
E2402	1	NEG PRESS WOUND THERAPY PUMP	3	$8,442
		Rationale: Nature of Equipment		
B4035	1	ENTERAL FEED SUPP PUMP PER D	30	$6,905
		Rationale: Code Descriptor / CPT Instruction		
B4034	1	ENTER FEED SUPKIT SYR BY DAY	22	$2,062
		Rationale: Code Descriptor / CPT Instruction		
A7020	1	INTERFACE, COUGH STIM DEVICE	11	$1,212
		Rationale: Nature of Equipment		
E0486	1	ORAL DEVICE/APPLIANCE CUSFAB	1	$1,194
		Rationale: Nature of Equipment		
L3002	2	FOOT INSERT PLASTAZOTE OR EQ	1	$1,128
		Rationale: Anatomic Consideration		
A7039	1	FILTER, NON DISPOSABLE W PAP	13	$669
		Rationale: Published Contractor Policy		
		Top 10 TOTAL	**689**	**$198,994**
		GRAND TOTAL	**760**	**$202,998**

Global Surgery Prohibited Fee Period Analysis

CMS created the definition of global surgical package to make payments for services provided by a surgeon before, during, and after procedures. The objective of CTI's Global Surgery Prohibited Fee Period Analysis is to compare paid surgical claims to Medicare's payment guidelines and identify instances of unbundling and improper use of evaluation and management (E/M) coding.

Scope

The scope of the Global Surgery Prohibited Fee Period Analysis is surgery charges provided in any setting, including inpatient hospital, outpatient hospital, ambulatory surgical center (ASC), and physician's office. Claims for surgeon visits in intensive care or critical care units are also included in the global surgical package. Our analysis encompasses the three types of procedures with global surgical packages: simple, minor, and major. Each type has specific global periods:

- Simple – One day
- Minor – Ten days
- Major – Ninety days

CMS allows providers to bill for an E/M service after surgery if the patient's condition required a significant, separately identifiable E/M service beyond the usual pre-operative and post-operative care. When this occurs, the provider can add a modifier 24, 25, or 57 to the E/M service procedure code but must submit supporting documentation with the claim.

Report

The following report provides a summary of:

- top 10 providers with and without E/M charges during prohibited periods and associated charges;
- analysis of the same providers' surgeries with modifier 24, 25, or 57 when Medicare would have required supporting documentation before payment; and
- analysis of the same providers' surgeries without modifier 24, 25, or 57 when Medicare would have denied payment.

Payment of unbundled, post-surgical E/M services during the global fee period increases the cost of a claim. While there are no universally accepted guidelines for global surgery fee periods with 24, 25, or 57 modifiers, some states and groups mandate providers accept assignment of benefits on those claims. This mitigates the financial impact of unbundling and improper coding. When we discuss our findings, we will help you identify strategies to monitor and eliminate unbundling within the State's plan.

State of Montana - Allegiance Benefit Plan Management									
Audit Period 1/1/2020 - 12/31/2021									
	Surgeries with 'CMS Defined' Prohibited Global Fee Periods					Evaluation and Management Services using Same ID as Surgeon and Within Prohibited Global Fee Period			
	Surgeries without E/M Procedures during Prohibited Global Fee Periods		Surgery with E/M Charge during Prohibited Global Fee Periods			E/M Procedure Codes with Modifier 24, 25, or 57		E/M Procedure Codes without Modifier 24, 25, or 57	
Provider Id	Count	Allowed Charge	Count	% Surgeries with E/M Charges during Prohibited Global Fee Periods	Allowed Charge	Total Count; 0,10 & 90 days	Allowed Charge	Total Count; 0,10 & 90 days	Allowed Charge
	4	$3,700	5	55.6%	$6,250	3	$463	2	$543
	192	$82,093	23	10.7%	$11,934	22	$3,579	2	$507
	21	$43,545	4	16.0%	$7,462	1	$167	2	$446
	3	$614	2	40.0%	$399	0	$0	2	$359
	82	$89,762	44	34.9%	$15,816	41	$6,205	2	$346
	0	$0	1	100.0%	$3,142	0	$0	1	$326
	231	$80,219	39	14.4%	$10,098	36	$3,203	3	$301
	7	$3,112	1	12.5%	$1,225	0	$0	1	$271
	16	$9,704	3	15.8%	$1,966	1	$179	1	$271
	54	$29,597	6	10.0%	$2,728	4	$590	1	$271
Top 10	**610**	**$342,346**	**128**	**17.3%**	**$61,020**	**108**	**$14,386**	**17**	**$3,643**
Overall Total	**17,882**	**$6,703,561**	**4,130**	**18.8%**	**$1,055,942**	**3,910**	**$579,038**	**82**	**$11,052**

CONCLUSION

We consider it a privilege to have worked for, and with, your staff and administrator. Our contract offers eight hours of post-audit time to help you develop an implementation plan should the State desire additional assistance in that regard.

Thank you again for choosing CTI.

APPENDIX A – SAMPLE CONSTRUCTION AND WEIGHTING METHODOLOGY

Client: MTAllegiance21
Audit Period: January 01, 2020 - December 31, 2021

Claim Universe (as converted)

Stratum		Claim Count	Total Charge Amount	Total Paid Amount
<=500	1	666,346	$107,043,422	$50,539,141
<=10,000	2	125,127	$217,027,253	$80,785,798
>10,000	3	10,645	$332,800,489	$128,057,511
	Totals	802,118	$656,871,164	$259,382,450

Audit Stratification

Stratum		Audit Universe (# Claims)	Proportion (Weight by Count)	Sample
<=500	1	666,346	83.07%	60
<=10,000	2	125,127	15.60%	60
>10,000	3	10,645	1.33%	59
	Totals	802,118	100.00%	179

Audit Sample Overview

Category	Count	Paid Amount
Claims requested for audit	180	$950,865.00
Claims for which records not received	0	$0.00
Claims outside scope of audit	1	$17,757.17
Claims as entered included in audit sample	179	$933,107.83
Audit sample if all claims paid correctly	179	$933,122.76
Claims with inadequate documentation	0	$0.00
Total claim payments remaining in audit sample	179	$933,122.76

APPENDIX B – ADMINISTRATOR RESPONSE TO DRAFT REPORT

The administrator's response to the draft report follows.

ALLEGIANCE BENEFIT PLAN MANAGEMENT'S RESPONSE TO CTI AUDIT RESULTS FOR THE STATE OF MONTANA EMPLOYEE HEALTH BENEFIT PLAN FOR PERIOD JANUARY 1, 2020 THROUGH DECEMBER 31, 2021

Allegiance Benefit Plan Management, Inc. (Allegiance) has reviewed the results issued by CTI of its performance audit for the period from January 1, 2020 through December 31, 2021 of the State of Montana Employee Health Benefit Plan for which Allegiance provides third party administrator services. Based upon that review, Allegiance in large part agrees with the audit findings which confirm the superior quality of services provided by Allegiance. However, Allegiance has identified 3 findings to which Allegiance disagrees.

First, on page 7 there is a reference to NCCI coding edits in part being turned off. This has been discussed in prior audits:

Coding edits are turned on for professional claims through an editing service company called Zelis and for institutional claims through the reference based pricing performed by Payer Compass. As we have discussed, code editing is very complex with hundreds of thousands of coding rules from the National Comprehensive Coding Initiative (Medicare), the CPT and HCPCS coding manuals, and various Association rules and recommendations. The reason that an edit may not always trigger is that there is a significant difference between the existence of an edit and the processing of an edit such that quite often the edit is allowed to be bypassed in the coding rules. One such situation is through the use of modifiers. Use of modifier 25 (Significant, Separately Identifiable Evaluation and Management Service by the same Physician), 57 (Decision for Surgery), or 59 (Distinct Procedural Service) will all allow edits to be bypassed in certain situations. There are also many more such modifiers and other qualifiers that allow edits to be bypassed even when they are turned on. In addition some specific edits have been customized to be turned off. For example, the edit which denies the charge for drawing blood has been turned off because the minimal charge, and especially the minimal payment after PPO discount, is not a risk to the Plan and is a good investment when compared to the displeasure and discontent it causes the members, HR and providers. In summary, just because an edit exists does not mean it will always apply per the rules or that it always makes sense to apply it.

Second, on page 8 there is an outstanding overpayment refund in the amount of $40,523.41 that Allegiance Benefit Plan Management was unable to collect from providers. However, per our contract with the State of Montana Health Benefit Plan this amount was reimbursed to the Plan in February of 2022. The report provided to CTI was also provided to the State of Montana Health Benefit Plan to confirm the amount owed.

Third, on page 15 there was an error assigned on a small claim that was not found during audit for correction. It was identified and corrected 18 months prior to the audit. Technically, this is not a CTI audit finding and Allegiance disagrees with this claim being included in the financial and procedural error percentages.

DocuSigned by:
Kim Browne
4CF6F04173A14EB...

Kimberly A. McGuire-Browne
Senior Vice-President
Allegiance Benefit Plan Management, Inc.

CLAIM TECHNOLOGIES INCORPORATED

100 Court Avenue – Suite 306 • Des Moines, IA 50309

(515) 244-7322 • claimtechnologies.com

Comprehensive Claim Administration Audit

EXECUTIVE SUMMARY REPORT

State of Montana Dental Plans

Administered by Delta Dental Insurance Company

Audit Period: January 1, 2020 through December 31, 2021

Presented to

State of Montana

March 25, 2022

CLAIM TECHNOLOGIES INCORPORATED

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INTRODUCTION

This ***Executive Summary*** contains CTI's findings and recommendations from our audit of Delta Dental Insurance Company's (Delta) administration of the dental plan managed by the Health Care and Benefits Division within the Montana Department of Administration and subject to the oversight of the State of Montana Legislative Audit Division (the State). You can review the detail that supports CTI's findings and recommendations in our ***Specific Findings Report***.

CTI conducted the audit according to accepted standards and procedures for claim audits in the health insurance industry. We based our audit findings on the data and information provided by the State and Delta. The validity of our findings relies on the accuracy and completeness of that information. We planned and performed the audit to obtain a reasonable assurance claims were adjudicated according to the terms of the contract between Delta and the State as well as all approved plan documents and communications.

CTI specializes in the audit and control of health plan claim administration. Accordingly, the statements we make relate narrowly and specifically to the overall effectiveness of policies, procedures, and systems Delta used to pay the State's claims during the audit period. While performing the audit, CTI complied with all confidentiality, non-disclosure, and conflict of interest requirements and did not receive anything of value or any benefit of any kind other than agreed upon audit fees.

OBJECTIVES AND SCOPE

The objectives of CTI's audit of Delta's claim administration were to determine whether:

- Delta followed the terms of its contract with the State;
- Delta paid claims according to the provisions of the plan documents and if those provisions were clear and consistent;
- Members were eligible and covered by the State's plans at the time a service paid by Delta was incurred; and
- Any claim administration or eligibility maintenance systems or processes need improvement.

CTI audited Delta's claim administration of the State dental plans for the period of January 1, 2020 through December 31, 2021. The population of claims and amount paid during that period were:

Total Paid Amount	$13,620,137
Total Number of Claims Paid/Denied/Adjusted	94,510

The audit included the following components which are described in greater detail on the following pages:

- Operational Review and Questionnaire
- Plan Documentation Analysis
- 100% Electronic Screening with 15 Targeted Samples
- Random Sample Audit of 110 Claims
- Data Analytics

AUDIT FINDINGS AND RECOMMENDATIONS

Random Sample Findings

CTI validated claim processing accuracy based on a sample of 110 dental claims paid or denied by Delta during the audit period. We selected the random sample (stratified by the claim billed amount) to provide a statistical confidence level of 95% +/- 3% margin of error.

CTI's Random Sample Audit categorizes errors into key performance indicators. We use this systematic labeling of errors and calculation of performance as the basis for the benchmarks generated using results from our most recent 40 dental claim audits.

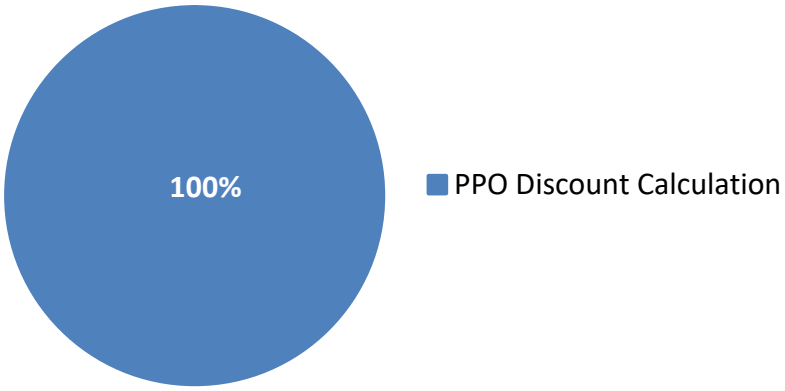
The following table illustrates Delta's performance was above the median in all three of CTI's benchmarked performance indicators.

Key Performance Indicators	Administrator's Performance by Quartile				
	Quartile 1	Quartile 2	MEDIAN	Quartile 3	Quartile 4
	Lowest →				*Highest*
Financial Accuracy: Compares total dollars associated with correct claim payments to total dollars of correct claim payments that should have been made.			**99.61%**	**99.94%**	
Accurate Payment: Compares number of correctly paid claims to total number of claims paid.			**98.33%**	**99.09%**	
Accurate Processing: Compares number of claims processed without any type of error (financial or non-financial) to total number of claims processed.			**97.90%**	**99.09%**	

Prioritization of Process Improvement Opportunities

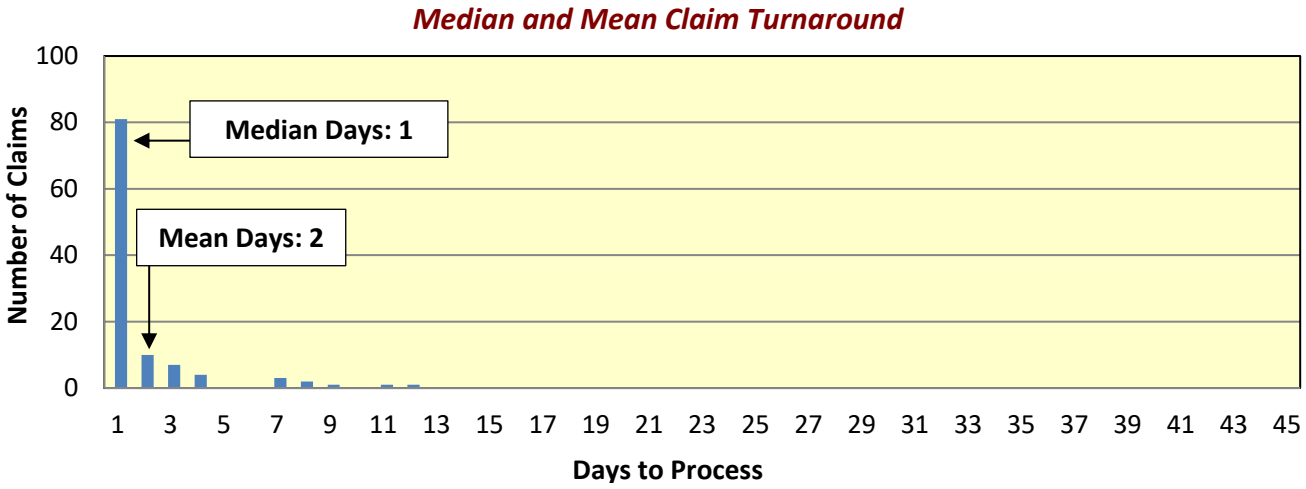
The following charts can help to prioritize improvement and/or recovery opportunities based on savings and service impact and to pinpoint problem causes.

Financial and Payment Accuracy by Error Type



Claim Turnaround Time

A final measure of claim administration performance is claim turnaround time. Through the audit sample, Delta demonstrated its median turnaround time on a complete claim submission was 1 days from the date it received a complete claim to the date the claim was paid or denied.



Random Sample Recommendation

Delta performed at a very high level during the audit period. The one error detected was related to a retroactive change in provider status. Page 15 of the Specific Findings Report has a detailed discussion of the error. Delta should use this error as an example of the importance of timely maintenance to provider records. Delta should be commended for recognizing the cause of the error. CTI recommends continued audits of Delta to ensure the high levels of performance demonstrated are sustained in the future.

100% Electronic Screening with Targeted Samples Findings

We used our proprietary Electronic Screening and Analysis System (ESAS) software to further analyze claim payment and eligibility maintenance accuracy as well as any opportunities for system and process improvement. Using the data file provided by Delta, we readjudicated each line on every claim the plan paid or denied during the audit period against the plan's benefits. Our Technical Lead Auditor tested a targeted sample of 15 claims to provide insight into Delta's claim administration as well as operational policies and procedures.

The following table shows the dental services identified as potentially overpaid. It is important to note that the amount shown represents potential payment errors; additional testing would be required to substantiate the findings and provide the basis for remedial action planning or recovery.

ESAS Candidates for Additional Testing	Potential Recovery
Duplicate Payments	**$53,595**
Limitations – Bitewing X-Rays 2 per plan year	**$33**

For specific information on the over and underpayments identified, see the ESAS section beginning on page 11 of CTI's ***Specific Findings Report***.

100% Electronic Screening with Targeted Samples Recommendations

The State should discuss the three errors identified with Delta. Two of the errors were manual, made by a claims processor, and should be addressed through coaching and counseling. Delta should determine the root cause of the error leading to duplicate claim payment to identify other claims that may have been affected. CTI can provide a list of potential duplicate claims for review.

Operational Review Findings

Delta completed our Operational Review Questionnaire and provided information on its:

- Systems, staffing, and workflow;
- Claim administration and eligibility maintenance procedures; and
- Internal control risk mechanisms, e.g., HIPAA protections; internal audit policies and practices; and fraud, waste, and abuse detection and prevention.

Our Operational Review indicated:

- Delta has performance guarantees with the State for the following measures: Eligibility, Claim Adjudication and Customer Service. Within those three categories, separate metrics are reported for Claims Turnaround Time, Overall Claims Accuracy, Customer Service Response Time, Customer Service Response and Account Management. Claims Turnaround Time, Overall Claims Accuracy, Customer Service Response Time, Customer Service and Customer Service Response guarantees are reported on a global basis and are not specific to the State. Delta's report to the State also included guarantees for Account Management, Provider Monitoring and Timely Reporting, although these measures were not indicated in Delta's response to our Questionnaire. Delta reported that all performance guarantees were met in 2020. For 2021, Delta provided a Performance Guarantee Report that included results for all metrics. Delta reported all performance guarantees were met.
- Delta does not provide dedicated claim or customer service personnel to the State, although a Sales Account Executive and Account Manager have overall responsibility for the State's account.
- Delta has a Business Continuity and Disaster Recovery program that is fully documented and tested at least annually. In the event of a disaster, customer-facing systems such as telephony, web and email are recovered in as little as 12 hours, core claims processing systems are recovered within 24 hours, and peripheral work and reporting systems are recovered within 72 hours.
- Delta can recoup overpayments to a participating dentist by withholding the overpayment on future checks. An overpayment made to a member is withheld from future payments until the balance is paid. If Delta is responsible for an overpayment and the funds cannot be recovered, Delta will credit the State's account for the overpayment.
- Delta complies with state laws requiring escheat of unclaimed checks.
- Delta's systems required security for ID and passwords. Passwords are changed automatically each 30 days. Access to the system required approval by the employee's manager and is granted based on role and business requirements described in the employee's job description.
- Claims examiners are not allowed to override any system-applied codes which require dental determination. Group benefits cannot be overridden. A dental consultant can give approval for an override for claims that require additional review.

- If a member has a signature on file, Delta allows assignment of benefits for non-network providers. CTI notes this practice is an effective way to guard against fraudulent claim payments that would otherwise be made directly to members.
- Delta had adequately documented training, workflow, procedures, and systems to provide consistently high levels of accuracy in the processing of claims and enrollment. Claims that require analysis or more complicated decision-making are handled by more experienced examiners. Claims that require review by a dental consultant are typically the last stop in claims processing. Delta conducts daily internal performance management audit on about 5% of all claims handled directly by claims examiners. Feedback regarding errors is given to the individual examiner who made the error.
- Delta reported COB savings of $80,843 for the period December 2019 through November 2020 and $61,841 for the period December 2020 through November 2021. No monthly breakdown of COB savings was provided so CTI cannot report the percentage of overall paid claims represented by COB savings during the audit period.
- Delta has no minimum amounts below which recovery of overpayments is not attempted. Repayments to participating dentists are withheld from future checks.
- During the calendar year 2020, 23 appeals were filed. Nineteen (82.61%) of those were resolved in favor of Delta. For the period of January 1 through June 1, 2021, 13 appeals were filed. Eleven of those (84.62%) were resolved in favor of Delta, upholding the original claim determination.
- Delta's Network Oversight and Compliance department conducts on-site examinations of dental offices to ensure member dentists are abiding by the terms of their agreements with Delta and investigate allegations of fraud.
- Staff responsible for investigating fraud have either a bachelor's degree in criminal justice or a related field and several years' dental claims auditing experience or over 10 years of dental claims/office experience.
- Delta uses state and federal databases to screen for providers who have been sanctioned by government programs.
- Delta uses internal tools to identify dentists who, when compared to peer group norms, are most likely engaging in questionable activities. Delta's systems enhance fraud-detection activities and provide information for practice intervention efforts directed at individual dentists. This helps Delta manage utilization within its network of dentists and protects clients from potential abuse.
- Delta indicated that 30.1% of claims come from network dentists but declined to provide a report showing discounts obtained from providers during the audit period.
- Delta reimburses dentists based on Maximum Contract Allowances (MCA) based on a review of claim charges submitted on a regional basis for a given service by dentists of similar training within the same geographical area. Fees are reviewed at least annually.
- Delta uses full-time dental consultants for claim review, pre-treatment estimate review and quality assessments. These individuals have a DDS/DMD degree, active licenses and at least five years' experience. Consultants attended continuing education and must maintain an active license.

- All employees are required to complete compliance training within 90 days of their hire date and annually thereafter.
- There were no breaches of members' information triggering notification requirements during the audit period.

Operational Review Recommendations

- The State should ask Delta to provide results against performance guarantees that are specific to the State. The current performance results are reported on a global basis, and may not capture errors unique to the State's account.
- The State should require Delta to provide sufficient detail in the claim file provided to its auditor to allow independent validation of self-reported provider discounts.

Plan Documentation Analysis Findings and Recommendations

Our Plan Documentation Analysis did not find any missing or ambiguous provisions in our review of the State's plan documents.

Data Analytics Findings

CTI used electronic claim data provided by Delta to identify whether Delta made payment to any provider on the Office of the Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE). OIG's LEIE provides information to the health care industry, patients, and the public about individuals and entities currently excluded from participation in Medicare, Medicaid, and all other federal health care programs.

Sanctioned Provider Identification

CTI screened 100% of non-facility provider claims from Delta against the Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE). No claims were paid to sanctioned providers during the audit period.

Data Analytics Recommendations

Delta should continue screening its providers to identify those who are on the LEIE.

CONCLUSION

We understand you will need to review these findings and recommendations to determine your priorities for action. Should the State desire additional assistance with this, our contract offers eight hours of post-audit time to help you create an implementation plan.

CTI also suggests that the State perform a follow-up audit to verify that Delta continues to perform above benchmark, and no new processing issues occur.

We consider it a privilege to have worked for, and with, your staff and we welcome any opportunity to assist you in the future. Thank you again for choosing CTI.

CLAIM TECHNOLOGIES INCORPORATED

100 Court Avenue – Suite 306 • Des Moines, IA 50309

(515) 244-7322 • claimtechnologies.com

Comprehensive Claim Administration Audit

SPECIFIC FINDINGS REPORT

State of Montana Dental Plans

Administered by Delta Dental Insurance Company

Audit Period: January 1, 2020 through December 31, 2021

Presented to

State of Montana

March 25, 2022

CLAIM TECHNOLOGIES INCORPORATED

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INTRODUCTION

This ***Specific Findings Report*** contains CTI's findings and recommendations from our audit of Delta Dental Insurance Company's (Delta) administration of the dental plan managed by the Health Care and Benefits Division within the Montana Department of Administration and subject to the oversight of the State of Montana Legislative Audit Division (the State). The statistics, observations, and findings in this report constitute the basis for the analysis and recommendations presented under separate cover in the ***Executive Summary***. We provide this report to the State, the plan sponsor, and Delta, the claims administrator. A copy of Delta's response to these findings can be found in Appendix B of this report.

CTI conducted the audit according to accepted standards and procedures for claim audits in the health insurance industry. We based our audit findings on the data and information provided by the State and Delta. The validity of our findings relies on the accuracy and completeness of that information. We planned and performed the audit to obtain a reasonable assurance claims were adjudicated according to the terms of the contract between Delta and the State.

CTI specializes in the audit and control of health plan claim administration. Accordingly, the statements we make relate narrowly and specifically to the overall effectiveness of policies, procedures, and systems Delta used to pay the State's claims during the audit period. While performing the audit, CTI complied with all confidentiality, non-disclosure, and conflict of interest requirements and did not receive anything of value or any benefit of any kind other than agreed upon audit fees.

Audit Objectives

The objectives of CTI's audit of Delta's claim administration were to determine whether:

- Delta followed the terms of its contract with the State;
- Delta paid claims according to the provisions of the plan documents and if those provisions were clear and consistent;
- members were eligible and covered by the State's plan at the time a service paid by Delta was incurred; and
- any claim administration or eligibility maintenance systems or processes need improvement.

Audit Scope

CTI audited Delta's claim administration of the State dental plan for the period of January 1, 2020 through December 31, 2021. The population of claims and amount paid during that period were:

Total Paid Amount	$13,620,137
Total Number of Claims Paid/Denied/Adjusted	94,510

The audit included the following components:

1. **Operational Review and Questionnaire**
   - Claim administrator information
   - Claim administrator claim fund account
   - Claim adjudication and eligibility maintenance procedures
   - HIPAA compliance

2. **Plan Documentation Analysis**
   - Plan documents and other approved communications
   - Administrative services agreement
   - Identify missing provisions, ambiguities, and inconsistencies

3. **100% Electronic Screening with 15 Targeted Samples**
   - Systematic analysis of 100% of paid claims
   - Problem identification and quantification

4. **Random Sample Audit of 110 Claims**
   - Statistical confidence at 95% +/- 3%
   - Key Indicator performance levels
   - Benchmarking
   - Identify and prioritize problems

5. **Data Analytics**
   - Provider Discounts
   - Sanctioned Provider Identification

OPERATIONAL REVIEW

Objective

CTI's Operational Review evaluates Delta's claim administration systems, staffing, and procedures to identify any deficiencies that materially affect its ability to control risk and pay claims accurately on behalf of the plan.

Scope

The scope of the Operational Review included:

- Claim administrator information
  - Insurance and bonding
  - Conflicts of interest
  - Internal audit
  - Financial reporting
  - Business continuity planning
  - Claim payment system and coding protocols
  - Data and system security
  - Staffing
- Claim funding:
  - Claim funding mechanism
  - Check processing and security; and
  - COBRA/direct pay premium collections
- Claim adjudication, customer service, and eligibility maintenance procedures:
  - Exception claim processing
  - Eligibility maintenance and investigation
  - Overpayment recovery
  - Customer service call and inquiry handling
  - Network utilization
  - Utilization review, case management, and disease management
  - Appeals processing
- HIPAA compliance

Methodology

CTI used an Operational Review Questionnaire to gather information from Delta. We modeled our questionnaire after the audit tool used by certified public accounting firms when conducting an SSAE 18 audit of a service administrator. We modified that tool to elicit information specific to the administration of the State's plan.

We reviewed Delta's responses and any supporting documentation supplied to gain an understanding of the procedures, staffing, and systems used to administer the State's plan. This allowed us to conduct the audit more effectively.

Findings

Claim Administrator Information

CTI reviewed information about Delta including:

- Background information
- Financial reports
- Insurance protection types and levels
- Dedicated staffing
- Systems and software
- Fee and commission disclosure
- Performance standards
- Internal audit practices

We observed the following:

- Delta provided the following insurance coverage information:

Coverage	Amount
Fidelity Bond/Crime Policy	$15,000,000 limit
Errors and Omissions	$100,000 ($500,000 self-insured retention)
Cyber Liability	$5,000,000

- Delta has performance guarantees with the State for the following measures: Eligibility, Claim Adjudication and Customer Service. Claims Turnaround, Claims Accuracy and Customer Service. Performance guarantees are reported on a global basis and are not specific to the State. Delta's report to the State also included guarantees for Account Management, Provider Monitoring and Timely Reporting, although these measures were not indicated in Delta's response to our Questionnaire. Delta reported that all performance guarantees were met in 2020. For 2021, Delta provided a Performance Guarantee Report that included results for all metrics. Delta reported all performance guarantees were met.

- Delta indicated it had been audited for compliance with the standards of the American Institute of Certified Public Accountants (AICPA) through the issuance of a Statement on Standards for Attestation Engagements (SSAE) No. 18, reporting on controls at a service organization. Under SSAE 18, the administrator is required to provide its own description of its system, which the service auditor validates. CTI has a copy of the audit reports for the periods of January 1, 2020 to December 31, 2020 and January 1, 2021 through June 30, 2021 which was prepared by Armanino LLP. In addition, Delta's Chief Financial Officer provided a bridge letter for the period of July 1, 2021 through November 30, 2021 stating Delta had not made any material changes in controls or the control environment since the prior SOC 18 report. Armanino's opinion for both reports is that Delta's assertion of its controls fairly presents the claims processing system used and that control objective stated were suitably designed to provide reasonable assurance that the control objectives would be achieved if they operated effectively and that in fact, the controls did operate effectively. No exceptions were identified in testing performed to validate controls over claims processing and related physical and system security.

- Delta does not provide dedicated claim or customer service personnel to the State, although a Sales Account Executive and Account Manager have overall responsibility for the State's account.
- Delta uses the MetaVance claims processing system which is a common platform used through the dental insurance industry. Business intelligence and reporting software are used within the system to identify billing and utilization patterns that are specific to procedures that are most apt to be upcoded.
- Delta has a Business Continuity and Disaster Recovery program that is fully documented and tested at least annually. In the event of a disaster, customer-facing systems such as telephony, web and email are recovered in as little as 12 hours, core claims processing systems are recovered within 24 hours, and peripheral work and reporting systems are recovered within 72 hours.

Claim Funding

CTI reviewed Delta's claim check controls and procedures for:

- Claim funding
- Fund reconciliation
- Refund and returned check handling
- Large check approval
- Security
- Stale check disposition
- Audit trail reports
- COBRA and retiree/direct pay premium collection

We observed the following:

- Delta can recoup overpayments to a participating dentist by withholding the overpayment on future checks. An overpayment made to a member is withheld from future payments until the balance is paid. If Delta is responsible for an overpayment and the funds cannot be recovered, Delta will credit the State's account for the amount of the overpayment.
- Delta complies with state laws requiring escheat of unclaimed checks.
- Delta's systems required security for ID and passwords. Passwords are changed automatically each 30 days. Access to the system required approval by the employee's manager and is granted based on role and business requirements described in the employee's job description.
- Claims examiners are not allowed to override any system-applied codes which require dental determination. Group benefits cannot be overridden. A dental consultant can give approval for an override for claims that require additional review.
- If a member has a signature on file, Delta allows assignment of benefits for non-network providers. CTI notes this practice is an effective way to guard against fraudulent claim payments that would otherwise be made directly to members.

Claim Adjudication, Customer Service, and Eligibility Maintenance Procedures

CTI reviewed Delta's enrollment, eligibility maintenance, and claim processing controls and procedures. We observed the following:

- Delta had adequately documented training, workflow, procedures, and systems to provide consistently high levels of accuracy in the processing of claims and enrollment. Claims that require analysis or more complicated decision-making are handled by more experienced examiners. Claims that require review by a dental consultant are typically the last stop in claims processing. Delta conducts daily internal performance management audit on about 5% of all claims handled directly by claims examiners. Feedback regarding errors is given to the individual examiner who made the error.
- Eligibility updates for the State are processed on a bi-weekly basis, on Wednesdays. Dependent eligibility is handled by the State.
- Delta collects coordination of benefits (COB) information at the time of enrollment and accepts updates at any time, which can change with the submission of a claim. Claims with missing COB information are denied and the dentist and the member are asked to resubmit the claim with the correct information. If a claim is processed and it is later discovered that there is other coverage, Delta will pursue the overpayment.
- Delta follows industry standard COB processing to ensure that the combined benefits from all a members' benefit plan will not exceed 100% of the amount Delta determines to be the total covered expense. Delta uses the birthday rule in determining primacy of coverage for dependents.
- Delta reported COB savings of $80,843 for the period December 2019 through November 2020 and $61,841 for the period December 2020 through November 2021. No monthly breakdown of COB savings was provided so CTI cannot report the percentage of overall paid claims represented by COB savings during the audit period.
- 77% of Delta claims are submitted electronically and more than 93.4% auto-adjudicate without human intervention before payment or denial.
- Delta has no minimum amounts below which recovery of overpayments is not attempted. Repayments to participating dentists are withheld from future checks.
- Delta Dental does not provide overpayment reports. All self-funded clients are automatically credited for claim adjustments on a weekly basis.
- During the calendar year 2020, 23 appeals were filed. Nineteen (82.61%) of those were resolved in favor of Delta. For the period of January 1 through June 1, 2021, 13 appeals were filed. Eleven of those (84.62%) were resolved in favor of Delta, upholding the original claim determination.
- Delta's Network Oversight and Compliance department conducts on-site examinations of dental offices to ensure member dentists are abiding by the terms of their agreements with Delta and investigate allegations of fraud.
- Staff responsible for investigating fraud have either a bachelor's degree in criminal justice or a related field and several years' dental claims auditing experience or over 10 years of dental claims/office experience.
- Delta Dental uses state and federal databases to screen for providers who have been sanctioned by government programs.

- Delta uses internal tools to identify dentists who, when compared to peer group norms, are most likely engaging in questionable activities. Delta's systems enhance fraud-detection activities and provide information for practice intervention efforts directed at individual dentists. This helps Delta manage utilization within its network of dentists and protects clients from potential abuse.
- Delta indicated that 30.1% of claims come from network dentists, but declined to provide a report showing discounts obtained from providers during the audit period.
- Delta reimburses dentists based on Maximum Contract Allowances (MCA) based on a review of claim charges submitted on a regional basis for a given service by dentists of similar training within the same geographical area. Fees are reviewed at least annually.
- Delta Dental uses full-time dental consultants for claim review, pre-treatment estimate review and quality assessments. These individuals have a DDS/DMD degree, active licenses and at least five years' experience. Consultants attended continuing education and must maintain an active license.

HIPAA Compliance

CTI reviewed information about the systems and processes Delta had in place to maintain compliance with HIPAA regulations. The objective was to determine if the administrator was aware of the HIPAA regulations and was compliant at the time of the audit. We observed the following:

- Delta has designated compliance with HIPAA and associated regulatory changes as one of its top corporate priorities. Delta's Department of Risk, Ethics and Compliance tracks, analyzes and implements federal and state laws for the enterprise. Ongoing review of policies and procedures occurs to comply with new laws and regulations.
- All employees are required to complete compliance training within 90 days of their hire date and annually thereafter.
- There were no breaches of members' information triggering notification requirements during the audit period.

PLAN DOCUMENTATION ANALYSIS

Objective

CTI's Plan Documentation Analysis evaluates the documents governing administration of the State's dental plan and identifies inconsistencies, ambiguities, or missing provisions that might negatively impact accurate claim administration. Through this evaluation, we gained an understanding of Delta's administrative service responsibilities for the State's dental plan. This understanding allowed us to audit more effectively.

Scope

Our auditors evaluated:

- Plan documents, descriptions, and any amendments
- Administrative services agreement

Methodology

CTI obtained a copy of the plan documentation from the State. Our auditors reviewed the applicable documents to better understand the provisions Delta should have used to adjudicate all dental claims.

CTI obtained clarification from the State about any inconsistencies in the plan documents. Our auditors then used the benefit matrix as a cross-reference tool as they audited claims.

Findings

Our auditors did not identify any inconsistencies, ambiguities, or missing provisions in our Plan Documentation Analysis.

100% ELECTRONIC SCREENING WITH TARGETED SAMPLE ANALYSIS

Objective

CTI's Electronic Screening and Analysis System (ESAS) software identified and quantified potential claim administration payment errors. The State and Delta should talk about any verified under- or overpayments to determine the appropriate actions to correct the errors.

Scope

CTI electronically screened 100% of the service lines processed by Delta during the audit period. The accuracy and completeness of Delta's data directly impacted the screening categories we completed and the integrity of our findings. We screened the following high-level ESAS categories to identify potential amounts at risk:

- Duplicate payments to providers and/or employees
- Plan exclusions and limitations

Methodology

We used ESAS to analyze claim payment accuracy as well as opportunities for system and process improvement. Using the data file provided by Delta, we readjudicated each line on every claim the plan paid or denied during the audit period against the plan's benefits. Our Technical Lead Auditor tested a targeted sample of claims to provide insight into Delta's claim administration as well as operational policies and procedures. We followed these procedures to complete our ESAS process:

- ***Electronic Screening Parameters Set*** – We used the State's plan document provisions to set the parameters in ESAS.
- ***Data Conversion*** – We converted and validated the State's claim data, reconciled it against control totals, and checked it for reasonableness.
- ***Electronic Screening*** – We systematically screened 100% of the service lines processed and flagged claims not administered according to plan parameters.
- ***Auditor Analysis*** – If claims within an ESAS screening category represented a material amount, our auditors analyzed the findings to confirm results were valid. When using ESAS to identify payment errors, note that incomplete claim data could lead to false positives. CTI auditors made every effort to identify and remove false positives.
- ***Targeted Sample Analysis*** – From the categories identified with material amounts at risk, we selected the best examples of potential under- or overpayments to test. As cases were not randomly selected, we cannot extrapolate results. We selected a total of 15 cases and sent Delta Dental a questionnaire for each. Targeted samples verified if the claim data supported our finding and if our understanding of plan provisions matched Delta's administration.
- ***Audit of Administrator Response and Documentation*** – We reviewed the responses and redacted the responses to eliminate personal health information. Based on the responses and further analysis of the findings, we removed false positives identified from the potential amounts at risk.

Findings

While we are confident in the accuracy of our ESAS results, note the dollar amounts associated with the results represent potential payment errors and process improvement opportunities. We would

have to perform additional testing to substantiate the findings that could then provide the basis for remedial action planning or reimbursement.

The following report shows, by category, the number of line items or claims and the total potential amount at risk remaining at the conclusion of our analysis, targeted samples, and removal of verified false positives. Following the report is a detailed explanation of our results with findings for all screening categories where, in our opinion, process improvement, recovery or savings opportunities exist. The administrator responses are copied directly from Delta's reply to audit findings.

Categories for Potential Amount at Risk					
Client: The State **Screening Period:** January 1, 2020 through December 31, 2021					
Category	**Lines**	**Claimants**	**Charge**	**Benefit**	**Potential at Risk**
Duplicate Payments					
Providers and/or Employees	2,769	487	$931,125	$53,595	$53,595
Plan Limitations					
Bitewing X-Rays 2 per plan year	3	1	$189	$99	$33

Electronic screening of all service lines processed revealed the potential for incorrectly paid claims. Analysis confirmed the opportunity for process improvement and further testing is warranted.

Duplicate Payment Detail Report			
QID	**Under/ Over Paid**	**Delta Response**	**CTI Conclusion**
2	$71.00	Agree. Issue Summary: Office that has termed 12/31/2020 however, the term date was originally set for 1/15/2021. The 12/31 corrected date was updated on 1/14/2021. Unfortunately claims were filed in those 14 days. The change was made because the Provider's letter was received by Provider Concierge and unfortunately was not followed up in the correct time frame. Claim was manually adjudicated.	Procedural deficiency and overpayment remain. This overpayment has been recouped.
3	$59.00	Agree. When same procedure codes submitted twice for the same date of service, system should pend EX-code 405 for examiner to review then examiner would deny for duplicate if history is on file. However, in this case the examiner did not follow all desk level procedures and paid this claim as duplicate in error. The claim has been adjusted to recoup overpayment as of 02/11/2022. Claim was manually adjudicated.	Procedural deficiency and overpayment remain. This overpayment has been recouped.

Plan Limitations Detail Report			
QID	**Under/ Over Paid**	**Delta Response**	**CTI Conclusion**
Dental Bitewing X-Rays 2 Per Plan Year			
5	$71.00	Disagree. 20212175001547 and 20210413002746 were paid, 20211685002335 voided, no benefit was exceeded on the plan limitation. At the time of processing, original claim was auto adjudicated.	Procedural deficiency and overpayment remain. Per page 135 of the plan booklet, charges for bitewing x-rays are covered only twice in a year by the plan.

RANDOM SAMPLE AUDIT

Objectives

The objectives of our Random Sample Audit were to determine if claims were paid according to plan specifications and the administrative agreement, to measure and benchmark process quality, and to prioritize areas of administrative deficiency for further review and remediation.

Scope

CTI's Random Sample Audit included a stratified random sample of 110 paid or denied claims. The statistical confidence level of the audit sample was 95%, with a 3% margin of error. A copy of the Sample Construction and Weighting Methodology Report for the sample is in Appendix A.

Delta's performance was measured using the following key performance indicators:

- Financial Accuracy
- Accurate Payment
- Accurate Processing

We also measured claim turnaround time, a commonly relied upon performance measure.

Methodology

Our Random Sample Audit ensures a high degree of consistency in methodology and is based upon the principles of statistical process control with a management philosophy of continuous quality improvement. Our auditors reviewed each sample claim selected to ensure it conformed to plan specifications, agreements, and negotiated discounts. We recorded our findings in our proprietary audit system.

When applicable, we cited claim payment and processing errors identified by comparing the way a selected claim was paid and the information Delta had available at the time the transaction was processed**. It is important to note that even if the sampled claim was subsequently corrected prior to CTI's audit, we have still cited the error so you can discuss how to reduce errors and re-work in the future with the administrator.**

CTI communicated with Delta in writing about any errors or observations using system-generated response forms. We sent Delta a preliminary report for its review and written response. We considered Delta's written response, as found in Appendix B, when producing our final reports.

Findings

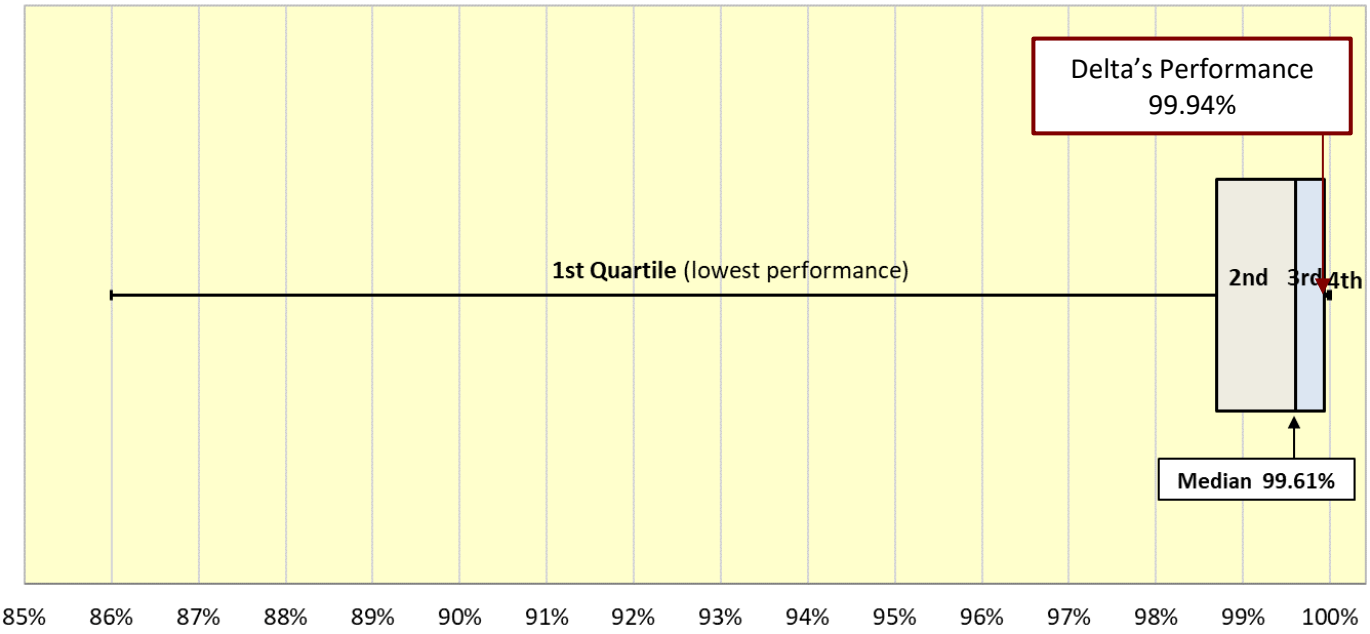
The following box and whiskers charts demonstrate Delta's performance as compared to the last 40 dental audits performed by CTI. The fourth quartile represents the 10 highest performing plans, and the first quartile represents the lowest 10. The Median is the point at which 20 plans audited were above, and 20 plans were below.

Financial Accuracy

CTI defines Financial Accuracy as the total correct claim payments made compared to the total dollars of correct claim payments that should have been made for the audit sample.

The claims sampled and reviewed revealed no underpayments and $24.00 in overpayments, for a combined variance of $24.00. The correct payment total for the adequately documented claims in the audit sample should have been $27,468.30.

The weighted Financial Accuracy rate was 99.94%.



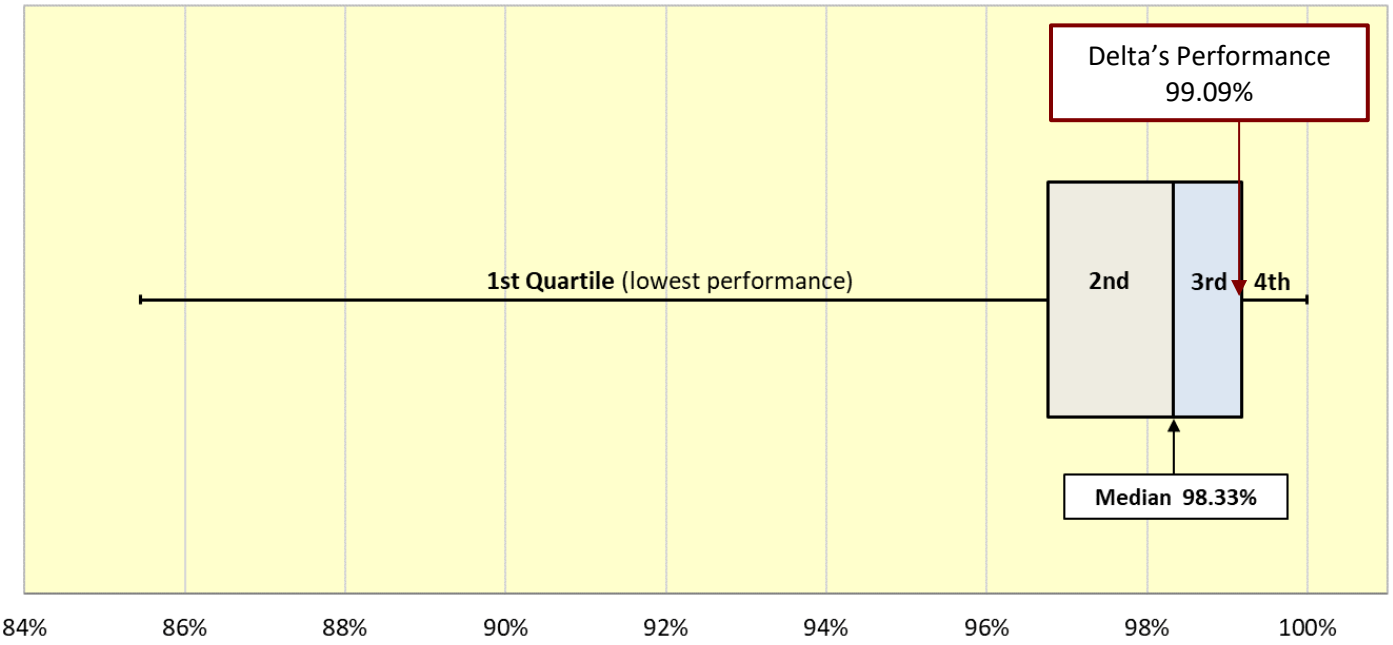
Financial Accuracy and Accurate Payment Detail Report					
Error Description	**Audit No.**	**Under/ Over Paid**	**Delta Response**	**CTI Conclusion**	**Manual or System**
PPO Discount Calculation	1004	$24.00	Agree. DCN #XXXXXXXXXX6882 is a deleted claim reference to SFXXXXXXXXXXXX7649 Office that has termed 12/31/2020 however, the term date was originally set for 1/15/2021. The 12/31 corrected date was updated on 1/14/2021. Unfortunately claims were filed in those 14 days. The change was made because the Provider's letter was received by Provider Concierge and unfortunately, was not followed up in the correct time frame. A request was requested to reprocess claim and new claim XXXXXXXXXX6509 was reprocessed to pay $147.00 with provider status of non-Par and the originally claim was recoup from provider.	Procedural error and overpayment remain. The sample claim was processed as PPO and the provider was non-PPO as of 12/31/20. The claim has been adjusted to apply the correct benefit.	☐ M ☒ S
Subtotal	**1**				
TOTALS	**1**	**VARIANCE $24.00**		**M: 0**	**S: 1**

Accurate Payment

CTI defines Accurate Payment as the number of claims paid correctly compared to the total number of claims paid for the audit sample.

The audit sample revealed 1 incorrectly paid claims and 109 correctly paid claims. Note CTI only uses adequately documented claims for this calculation.

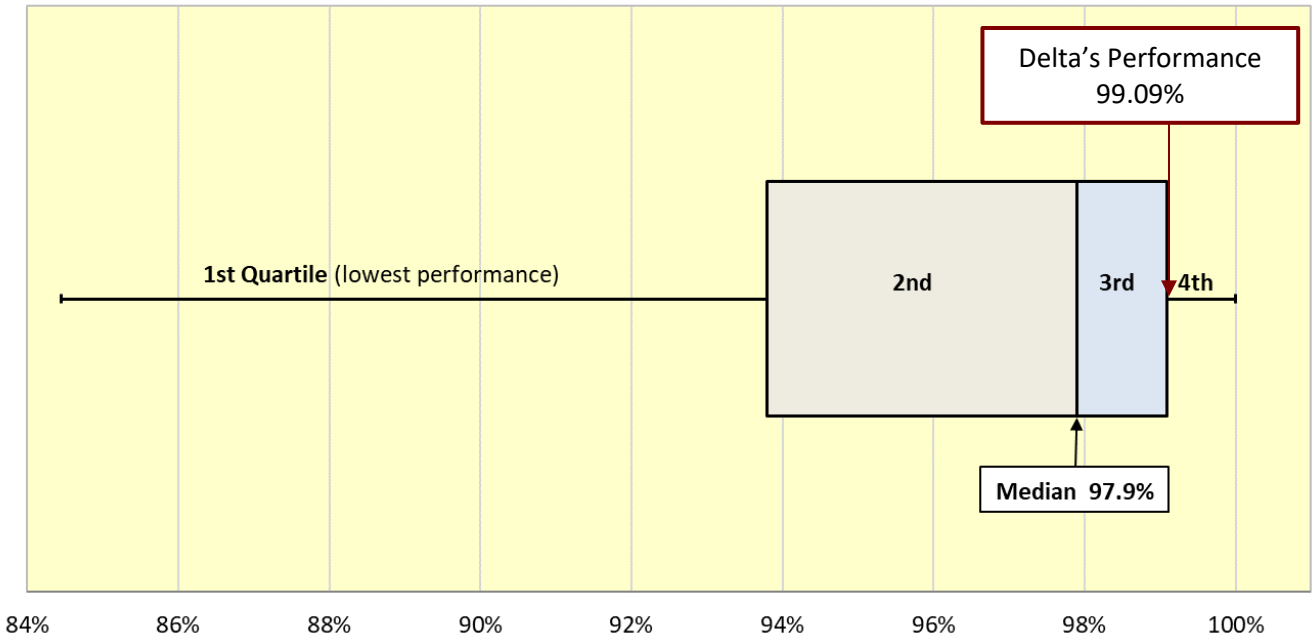
Total Claims	Incorrectly Paid Claims		Frequency
	Underpaid Claims	Overpaid Claims	
110	0	1	99.09%



Accurate Processing

CTI defines Accurate Processing as the number of claims processed without errors compared to the total number of claims processed in the audit sample. When a claim had errors that applied in more than one category, it was counted only once as a single incorrect claim for this measure.

Correctly Processed Claims	Incorrectly Processed Claims		Frequency
	System	Manual	
109	1	0	99.09%



Accurate Processing Detail Report				
Error Description	**Audit No.**	**Delta Response**	**CTI Conclusion**	**Manual or System**
Policy Provision				
PPO Discount Calculation	1004	Agree. DCN #XXXXXXXXXX6882 is a deleted claim reference to SFXXXXXXXXXXXX7649 Office that has termed 12/31/2020 however, the term date was originally set for 1/15/2021. The 12/31 corrected date was updated on 1/14/2021. Unfortunately claims were filed in those 14 days. The change was made because the Provider's letter was received by Provider Concierge and unfortunately, was not followed up in the correct time frame. A request was requested to reprocess claim and new claim XXXXXXXXX6509 was reprocessed to pay $147.00 with provider status of non-Par and the originally claim was recoup from provider.	Procedural error remains. The sample claim was processed as PPO and the provider was non-PPO as of 12/31/20. The claim has been adjusted to apply the correct benefit.	☐ M ☒ S

Claim Turnaround

CTI defines Claim Turnaround as the number of calendar days required to process a claim – from the date the claim was received by the administrator to the date a payment, denial, or additional information request was processed – expressed as both the Median and Mean for the audit sample.

Claim administrators commonly measure claim turnaround time in mean days. Median days, however, is a more meaningful measure for administrators to focus on when analyzing claim turnaround because it prevents one or just a few claims with extended turnaround time from distorting the true performance picture.

Median	Mean	+45 Days to Process
1	2	0

DATA ANALYTICS

This component of our audit used the State's electronic claim data to identify improvement opportunities and potential recoveries. The informational categories we analyzed include:

- Network Provider Utilization and Discount Savings;
- Sanctioned Provider Identification;

The following pages provide the scope and report for each data analytic to enable more-informed decisions about ways the State can maximize benefit plan administration and performance.

Network Provider Utilization and Discount Savings

The Network Provider Utilization and Discount Savings report provides an evaluation of provider network discounts obtained during the audit period. Since discounts can be calculated differently by administrators, carriers, and benefit consultants, we believe calculating discounts in the same manner for all our clients will allow for more meaningful comparisons to be made.

Report

We were unable to calculate provider discounts for the State because Delta did not provide them in electronic format.

Sanctioned Provider Identification

The Sanctioned Provider Identification report identifies services rendered by providers on the Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE). OIG's LEIE provides information to the healthcare industry, patients, and the public about individuals and entities currently excluded from participation in Medicare, Medicaid, and all other federal health care programs.

Scope

We received and converted an electronic data file of all claims processed during the audit period. Through electronic screening, we identified all claims in the audit universe.

Report

We screened 100% of non-facility claims against OIG's LEIE and there were no claims paid to providers on the OIG's LEIE.

CONCLUSION

We consider it a privilege to have worked for, and with, your staff and administrator. Our contract offers eight hours of post-audit time to help you develop an implementation plan should the State desire additional assistance in that regard.

Thank you again for choosing CTI.

APPENDIX A – SAMPLE CONSTRUCTION AND WEIGHTING METHODOLOGY

Sample Construction and Weighting Methodology

Client: MTDen21

Audit Period: January 01, 2020 - December 31, 2021

Claim Universe (as converted)

Stratum		Claim Count	Total Charge Amount	Total Paid Amount
<=250	1	66,186	$9,787,419	$5,887,242
<=500	2	14,921	$4,855,768	$2,139,232
>500	3	13,403	$19,068,102	$5,593,663
	Totals	94,510	$33,711,289	$13,620,137

Audit Stratification

Stratum		Audit Universe (# Claims)	Proportion (Weight by Count)	Sample
<=250	1	66,186	70.03%	36
<=500	2	14,921	15.79%	37
>500	3	13,403	14.18%	37
	Totals	94,510	100.00%	110

Audit Sample Overview

Category	Count	Paid
Claims requested for audit	110	$27,492.30
Claims for which records not received	0	$0.00
Claims outside scope of audit	0	$0.00
Claims as entered included in audit sample	110	$27,492.30
Audit sample if all claims paid correctly	110	$27,468.30
Claims with inadequate documentation	0	$0.00
Total claim payments remaining in audit sample	110	$27,468.30

APPENDIX B – ADMINISTRATOR RESPONSE TO DRAFT REPORT

Delta Dental's response to the draft report follows.

DELTA DENTAL®

deltadentalins.com

March 21, 2022

Ms. Michelle Suckow
Claims Technology Incorporated
100 Court Ave, Suite 306
Des Moines, IA 50309

Re: State of Montana Audit of Delta Dental

Dear Michelle

Thank you for the opportunity to review the draft audit report for our mutual client, State of Montana. As always, CTI has done a thorough and comprehensive review of Delta Dental and we appreciate the opportunity to partner with you to identify areas where we can improve service to State of Montana and its members.

At this time, we have no additional comments or edits to the report as presented. Our top priority remains to provide our members with a positive and successful experience on behalf of our client State of Montana.

A copy of this report is being shared with the claims operations management and account management team so that they can initiate the recommended training and address the true errors that were identified by CTI.

We look forward to jointly discussing the results of this audit at a future meeting with State of Montana Once again, thank you for your partnership.

Sincerely,

Jeffrey Almonte

Jeffrey Almonte
Regulatory Compliance Analyst

Brittany Chandler
Account Manager

Delta Dental Insurance Company
55 West 14th Street
Suite 101
Helena, MT 59601

Telephone: 406-449-0255
800-547-1986
Facsimile: 406-495-0322

CLAIM TECHNOLOGIES INCORPORATED

100 Court Avenue – Suite 306 • Des Moines, IA 50309

(515) 244-7322 • claimtechnologies.com

Prescription Benefit Management Audit of Navitus

EXECUTIVE SUMMARY

The State of Montana

Audit Periods

January 2020 – December 2020 and January 2021 – December 2021

Presented to

The State of Montana, Department of Administration, Health Care and Benefits Division

June 6, 2022

Prepared by

PillarRx Consulting

Subcontractor to

CLAIM TECHNOLOGIES INCORPORATED

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INTRODUCTION

This ***Executive Summary*** presents key findings and recommendations from PillarRx Consulting, LLC's (PillarRx) audit team has drawn from their Prescription Benefit Management Audit of Navitus Health Solutions LLC's (Navitus) administration of the pharmacy plan managed by the Health Care and Benefits Division within the Montana Department of Administration and subject to the oversight of the State of Montana Legislative Audit Division (the State). The information that these key findings and recommendations are based upon is detailed in the ***Specific Findings Report***.

These audit findings are based on data and information the State, as the plan sponsor, and Navitus, as the Pharmacy Benefit Manager (PBM) provided to PillarRx, and their validity relies upon the accuracy and completeness of that information.

The audit was planned and performed to obtain a reasonable assurance that prescription drug claims were adjudicated according to the terms of the contract between Navitus and the State as well as the benefit descriptions (summary plan descriptions, plan documents, or other communications) approved by the State.

PillarRx is a firm specializing in audit and control of pharmacy benefit plan administration. The State comments made by PillarRx in this report and the ***Specific Findings Report*** relate narrowly and specifically to the overall efficacy of Navitus' policies, processes, and systems relative to the State paid claims during the audit period.

Audit Objectives

The objectives of the PillarRx audit of Navitus's pharmacy benefit management were to:

- verify that claims were processed in accordance with the pricing terms specified in the contract;
- verify that claims adjudicated according to plan provisions;
- validate J-Code (codes used by hospitals, health care providers, and managed care organizations to identify injectable drugs and oral immunosuppressive medications) analysis of medical benefits, retail pharmacy network, mail order, and specialty programs.

Audit Scope

PillarRx's audit encompassed the contracts in force and the pharmacy benefit claims administered by Navitus for the audit periods of January, 2020 through December, 2020 and January, 2021 through December, 2021 for the State's Employee plan, as well as January, 2020 through December, 2020 and January, 2021 through December, 2021 for the State 's Medicare plan (Medicare Plan). The State's population of claims and the total net plan paid (total payment less member copayment) during this period was:

	Number of Prescriptions Paid	Net Plan Paid
Employee Plan 2020-2021	516,975	$88,147,908.33
Medicare Plan 2020-2021	115,925	$19,729,984.42

The audit included the following four components.

1. **Pricing and Fees Audit**
2. **Reconciliation of Pricing Guarantees**
3. **Benefit Payment Accuracy Review**
4. **J-Code Analysis**

Key findings for each component can be found in the following sections of this report. All work papers and system documentation in support of any finding will be provided to the State upon request.

KEY FINDINGS AND RECOMMENDATIONS

Pricing and Fees Audit

After verification of the electronic claim data provided by Navitus, PillarRx systematically re-priced 100% of prescription drug claims paid during the audit period to determine that:

- Discounts were applied correctly based on the lesser of Maximum Allowable Cost (MAC), Average Wholesale Price (AWP), and Usual and Customary (U&C); and
- Pharmacy dispensing and administrative fees were applied correctly.

Any errors identified in pricing or fees were shared with Navitus. Details of the discussion of those errors between PillarRx and Navitus, can be found under separate cover in the ***Specific Findings Report***.

Reconciliation of Pricing Guarantees

Using the terms of the State's contract with Navitus, we accumulated all prescription claims by type and distribution method for the period specified in the contract and balanced the total discount savings against the specified minimum discount guarantees. Similarly, all other performance guarantees were mapped against the actual prescription claims as adjudicated during the prescribed contract periods for performance guarantees. This reconciliation included the following contractual guarantees:

- AWP discounts applied for all drugs against third party pricing sources;
- MAC allowance for generic;
- Specialty drug allowance; and
- Dispensing fees.

Dispensing Fees

In the following chart, a **negative** variance indicates a higher than contracted dispensing fee collected. A **positive** variance indicates a lower than contracted dispensing fee collected.

	Employee Plan Dispensing Fees	Medicare Plan Dispensing Fees
Audit Period	**Variance Total Overage/(Shortfall)**	
1/1/2020 – 12/31/2020	**($6,451.00)**	**($20,866.00)**
1/1/2021 – 12/31/2021	**$10,146.00**	**($19,888.00)**

Discounts

The following chart shows discounts for both the State Employee and Medicare plans.

Key	Over Performance *> Greater Than Contracted Rates*	Acceptable Performance *— Same as Contracted Rates*	Under-Performance *< Less Than Contracted Rates*

Employee Plan Discounts				
Audit Period	**Contracted Claim Ingredient Cost**	**Actual Claim Ingredient Cost**	**Variance Total Overage/(Shortfall)**	
1/1/2020 – 12/31/2020	**$49,245,269.86**	**$48,020,840.00**	**$1,224,429.86**	**>**
1/1/2021 – 12/31/2021	**$53,274,943.66**	**$51,856,339.00**	**$1,418,604.66**	**>**

Medicare Plan Discounts				
Audit Period	**Contracted Claim Ingredient Cost**	**Actual Claim Ingredient Cost**	**Variance Total Overage/(Shortfall)**	
1/1/2020 – 12/31/2020	**$10,904,815.60**	**$10,636,775.00**	**$268,040.60**	**>**
1/1/2021 – 12/31/2021	**$10,986,631.50**	**$10,408,500.00**	**$578,131.50**	**>**

When aggregating dispensing fee calculations with the discounts achieved, PillarRx confirmed that Navitus over performed in both Employee and Medicare plans Discounts for both audit periods.

Note that the contract between Navitus and the State allows Navitus to offset a financial overage in one of the following areas: retail network, mail service and rebates to offset a shortfall in another. Based on the contractual terms between the State and Navitus to allow offsetting. No further action is necessary.

Combined Discount and Dispending Fee Guarantee Reconciliation
The following table includes calculations completed by Pillar Rx and demonstrate the total AWP discounts achieved by Navitus for years 2020 and 2021 for both Employee and Medicare plans.

	PillarRx Combined Discounts and Dispensing Fee Guarantee Reconciliation	
Employee Plan	**2020**	**2021**
Discounts	$1,224,429.86	$1,418,605.00
Dispensing Fees	($6,451.00)	$10,149.00
Total Achieved	$1,217,979.00	$1,428,754.00
Total Missed	$0.00	$0.00
Amount Due to the State	$0.00	$0.00
Medicare Plan	**2020**	**2021**
Discounts	$268,040.60	$578,131.50
Dispensing Fees	($20,866.00)	($19,888.00)
Total Achieved	$247,174.00	$558,243.50
Total Missed	$0.00	$0.00
Amount Due to the State	$0.00	$0.00

Benefit Payment Accuracy Review

PillarRx created an exact model of the benefit plan parameters of the State ’s pharmacy plan in AccuCAST and systematically re-adjudicated 100% of paid prescription drugs. Benefit plan parameters analyzed included, but were not limited to:

- Age and gender
- Copay/coinsurance
- Day supply maximums
- Excluded drugs
- Prior authorizations
- Quantity limits
- Refill limits
- Zero balance claims

Exceptions that were identified, but could not be explained by PillarRx’s benefit analysts, were provided to Navitus for explanation. When adequate documentation was provided to support exceptions were adjudicated correctly, AccuCAST was reset to represent the revised plan parameters and the claims were electronically re-adjudicated again to ensure consistency.

Copayments
Copayments represented the dollar amount required to be paid by the member when a prescription drug was purchased. Our observations and conclusions relative to copayment application for both the Employee and Medicare plans are shown in the following charts.

Employee Plan Copays 01/01/2020 – 12/31/2021				
Total Claims	**Copays per Plan**	**Copays Collected**	**Variance**	**Variance%**
516,975	$19,669,403.08	$19,669,403.08	$0.00	0%

Medicare Plan Copays 01/01/2020 – 12/31/2021				
Total Claims	**Copays per Plan**	**Copays Collected**	**Variance**	**Variance%**
115,925	$2,112,132.39	$2,112,132.39	$0.00	0%

After review of Navitus' responses, PillarRx agrees that copays adjudicated according to plan design specifications.

Drug Exclusions/Prior Authorizations
PillarRx found no issues related to drug exclusions and prior authorizations.

Administration of Age Rules
PillarRx found no issues related to age rules.

Administration of Quantity Limits
PillarRx found that based on the language in the drug coverage documents provided by Navitus, claims are adjudicating within the parameters.

J-Code Analysis

As healthcare continues to evolve with new treatments and cures for complex and chronic diseases, managing treatment protocols and identifying cost-containment strategies is critical. Pharmacy costs are 20-30% of total healthcare spend with specialty drug treatments driving the narrative. While these medications have become life-changing, it is estimated that within the next few years, specialty medications will meet or exceed 55% of overall total pharmacy gross costs and will have the same impact in absolute dollars under the medical benefit.

Medical Data Analysis
PillarRx's medical specialty drug analysis tool uses J-Codes as part of the Healthcare Common Procedure Coding System (HCPCS) Level II set of procedure codes. J-Codes are the codes used by the medical claim payer to price and process a claim, including the drug product and any additional fees that may be associated such as where the drug is administered, the provider professional fee, etc.

Pharmacy Data Analysis
PillarRx's pharmacy specialty drug analysis uses proprietary benchmarks and algorithms. A pharmacy vendor uses national Drug Code (NDC) numbers to pay a drug claim, and additional benchmarks are incorporated into the algorithms to understand dosing and duration to identify both clinical accuracy and potential waste with inefficiencies.

A crosswalk between each medical and pharmacy claim was created by matching the employee ID and social security number along with the relationship code to the subscriber, the gender, and date of birth.

Over 1,000 medications were reviewed in totality. The following chart represents a comprehensive review of 100% of the State's specialty drug claims under both medical and pharmacy that will facilitate a strategic, long-term solution for managing your pharmacy spend.

Benefit Channel	Total Gross Claim Cost	Total Plan Cost *	Claim Count
Pharmacy	**$ 129,659,428.82**	**$ 107,877,892.75**	**632,900**
Medical			
Ambulance - Land	$ 13.60	$ 5.97	8
Ambulatory Surgical Center	$ 9,240.25	$ 8,186.96	20
Emergency Room – Hospital	$ 138,499.02	$ 100,659.44	2,174
Federally Qualified Health Center	$ 1,372.90	$ 1,353.58	10
Home	$ 3,581,283.83	$ 3,347,088.17	647
Inpatient Hospital	$ 59,659.46	$ 54,698.06	67
Office	$ 10,845,077.58	$ 9,309,671.28	6,616
On Campus-Outpatient Hospital	$ 19,716,085.52	$ 16,320,757.11	13,066
Rural Health Clinic	$ 8,882.19	$ 8,779.92	40
Telehealth	$ -	$ -	2
Urgent Care Facility	$ 287.32	$ 49.86	184
Hospital	$ 31,999.47	$ 15,966.90	57
Managed Care Pharmacy	$ 508.20	$ 181.50	7
Total Medical	**$ 34,392,909.34**	**$ 29,167,398.75**	**22,898**
Grand Total	**$ 164,052,338.16**	**$ 137,045,291.50**	**655,798**

**No member cost share included.*

PillarRx's analysis of these transactions provides:

- Financial understanding of the various delivery sites of care under the two benefit channels;
- Understanding of drug claim payments within the medical benefit, which may vary in cost based on where the medication is administered to the member;
- Recommended policies/procedures for benefit coverage;
- Improved rebate savings opportunities; and
- Identification of medical/pharmacy claims overlap and duplication of payment.

Channel Benchmarks and Site of Care

PillarRx analyzes the medical and pharmacy claims data to:

- Identify differences in pricing (per unit) under both benefits.
- Identify the most appropriate delivery channel or point of access based on diagnosis/indication of drugs and by route of administration.
- Clinically assess medical necessity guidelines, business rules, and site of care delivery for both medical and pharmacy benefits.

This is followed by a high-level clinical review to assure each member is receiving an appropriate drug for an appropriate diagnosis for each medication filled. The review compares all specialty claims within each member's profile with an implied diagnosis for each medication. Within each implied diagnosis,

PillarRx assures all utilization is appropriate by drug. Once confirmed, the next step is to review benefit channels and the specific site of service or care findings.

The parameters used for the findings are as follows:

- Exclude all oncology indications/medications.
- Ensure claim count based on 30-day supply (if filled for 90days, claim count equals three).
- Include specialty drug medications that were filled at two or more sites of administration.
- Include only specialty drug medications with cost averages greater than or equal to $500.
- Exclude if no actual or implied rebate information included with cost information.

The results of PillarRx's analysis, documented in detail in the ***Specific Findings Report***, show opportunities for cost savings based on site of care.

PillarRx identified opportunities for potential savings if the State chose to direct members to a different channel and/or a different site of care within the same channel. Assuming 100% transition to the most favorable channel, there is a potential savings of approximately $11.5 million.

Two or More Channels or Sites of Care			
Optimal Site of Care	**Sum of Claim Count**	**Total Allowed Amount**	**Potential Movement Savings**
Home	654	$6,445,657.30	$1,567,806.98
Pharmacy	1,461	$1,708,580.14	$1,134,521.68
Medical Office	1,246	$7,125,509.66	$2,560,449.98
On-Campus Outpatient Hospital	2,381	$7,931,848.59	$2,861,805.80
Federally Qualified Health Center	672	$704,149.11	$301,653.81
Inpatient Hospital	271	$2,482,234.06	$1,951,991.36
Emergency Room	414	$1,044,203.07	$984,254.91
Ambulatory Surgical Center	483	$582,349.71	$191,464.71
TOTAL	**7,582**	**$28,024,531.64**	**$11,553,949.23**

Rebate Savings Opportunities

As illustrated in detail in the ***Specific Findings Report***, PillarRx prepared a comparative analysis between actual medical claims and pharmacy claim data for the same Generic Product Indicator (GPI). This demonstrates the advantage of moving drugs from the medical benefit to the pharmacy benefit.

Assuming a 30-day supply of medications and standard rebate amount of $450, an estimated $2.6 million could have been achieved during the audit period by combining both the Employee and Medicare plans for purposes of calculating rebate savings.

Upon completion of this report, the State informed PillarRx that some site of care savings and improved rebate opportunities have already been implemented with the State's medical plan administrator.

Duplicative Reimbursement

PillarRx analyzes claims to determine whether the medical and a pharmacy benefit were being billed for the same drug for the same member at the same time. Duplicate therapy is a wasteful practice that allows a subscriber and/or provider to be paid simultaneously and is a prevalent and costly issue. This analysis is designed to help you avoid double payments and any potential associated waste.

PillarRx reviews the State's data to identify any potential duplicative reimbursement circumstances. For the State, PillarRx identified no members who received the same specialty medication from both the medical benefit and the pharmacy benefit at the same time. Our analysis compares the fill date on the pharmacy claim to the incurred date on the medical claim for the same drug. If the difference between those dates was less than 15 days, it was considered a potential situation of double-dipping.

PillarRx found there was no overlap in coverage between medical and pharmacy claims for the State.

CLAIM TECHNOLOGIES INCORPORATED

100 Court Avenue – Suite 306 • Des Moines, IA 50309

Telephone: (515) 244-7322 • Fax: (515) 244-8650 • Website: claimtechnologies.com

Prescription Benefit Management Audit of Navitus

SPECIFIC FINDINGS REPORT

The State of Montana

Audit Periods

January 2020 – December 2020 and January 2021 – December 2021

Presented to

The State of Montana, Department of Administration, Health Care and Benefits Division

June 6, 2022

Prepared by

PillarRx Consulting

Subcontractor to

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ACRONYMS USED IN THIS REPORT

Acronym	Definition
AWP	Average Wholesale Price
DS	Day Supply
HCPCS	Healthcare Common Procedure Coding System
J-Codes	Procedure Codes for Specialty Medications
MAC	Maximum Allowable Cost
MPA	Member Prior Authorization
NC	Non-Covered
NDC	National Drug Code
NPI	National Provider Identifier
PA	Prior Authorization
PBM	Pharmacy Benefit Manager
U&C	Usual and Customary

INTRODUCTION

This Specific Findings Report contains detailed information, findings, and conclusions the PillarRx Consulting, LLC's (PillarRx) audit team has drawn from their Prescription Benefit Management Audit of Navitus Health Solutions LLC's (Navitus) administration of the pharmacy plan managed by the Health Care and Benefits Division within the Montana Department of Administration and subject to the oversight of the State of Montana Legislative Audit Division (the State). The statistics, observations, and findings in this report constitute the basis for the analysis and recommendations presented under separate cover in the Executive Summary. This Specific Findings Report is provided to the State, the plan sponsor, and Navitus, the pharmacy benefit manager (PBM).

The findings in this report are based on data and information Navitus and the State provided to PillarRx and the report's validity relies upon the accuracy and completeness of that information.

The audit was planned and performed to obtain a reasonable assurance that prescription drug claims were adjudicated according to the terms of the contract between Navitus and the State as well as Client approved benefit descriptions (summary plan descriptions, plan documents or other communications).

PillarRx is a firm specializing in audit and control of pharmacy benefit plan administration. The statements made by PillarRx in this report relate narrowly and specifically to the overall efficacy of Navitus's policies, processes, and systems relative to the State's paid claims during the audit period. While performing the audit, PillarRx complied with all confidentiality, non-disclosure, and conflict of interest requirements and did not receive anything of value or any benefit of any kind other than agreed upon audit fees.

Audit Objectives

The objectives of the PillarRx audit of Navitus's pharmacy benefit management were to:

- verify that claims were processed in accordance with the pricing terms specified in the contract;
- verify that claims adjudicated according to plan provisions;
- validate J-Code (codes used by hospitals, health care providers, and managed care organizations to identify injectable drugs and oral immunosuppressive medications) analysis of medical benefits, retail pharmacy network, mail order, and specialty programs.

Audit Scope

PillarRx's audit encompassed the contracts in force and the pharmacy benefit claims administered by Navitus for the audit periods of January, 2020 through December, 2020 and January, 2021 through December, 2021 for the State's Employee plan (Employee plan), as well as January, 2020 through December, 2020 and January, 2021 through December, 2021 for the State's Medicare plan (Medicare plan) plan. The State's population of claims and the total net plan paid (total payment less member copayment) during this period was:

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Employee Plan 2020-2021	516,975	$88,147,908.33
Medicare Plan 2020-2021	115,925	$19,729,984.42

The audit included the following four components.

1. **Pricing and Fees Audit**
2. **Reconciliation of Pricing Guarantees**
3. **Benefit Payment Accuracy Review**
4. **J-Code Analysis**

Key findings for each component can be found in the following sections of this report. All work papers and system documentation in support of any finding will be provided to the State upon request.

PRICING AND FEES AUDIT

Pricing and Fees Audit Objective

The Pricing and Fees Audit verified claims were processed in compliance with the discounts and fees specified in Navitus's contract with the State.

Pricing and Fees Audit Scope

After verification of the electronic claim data provided by Navitus, PillarRx systematically re-priced 100% of prescription drug claims paid during the audit period to determine that:

- Discounts were applied correctly based on the lesser of Maximum Allowable Cost (MAC), Average Wholesale Price (AWP), and Usual and Customary (U&C); and
- Pharmacy dispensing and administrative fees were applied correctly.

Pricing and Fees Audit Methodology

Contract Document Review

PillarRx requested and received from the State and Navitus all contracts, amendments, formulary drug lists, and reconciliation documents.

Claim Validation

We mapped and validated the raw claim data provided by Navitus to our standard layout. Raw claim data represented the successive pharmacy claim transactions that included both paid and reversed claims and was critical to our understanding of Navitus's processing and adjudication rules. Once mapped, the data was reconciled against control totals and put through a rigorous process referred to at PillarRx as data forensics – or the verification of claim data by assessing appropriate patterns and relationships. The data forensics included comparing the mapped data to the following benchmarks:

- Prior authorizations
- Rejections
- Reversals
- National Provider Identifier (NPI)
- National Drug Code (NDC)

To complete the claim validation, we conducted a conference call with Navitus to verify that:

- Pharmacy benefit claims data provided for this audit was complete and accurate;
- Claims were loaded correctly into the PillarRx system; and
- Claim counts and total paid claim amounts were accurate.

Pricing and Fees Analysis

The analysis of pricing and fees included electronic comparison of the pharmacy reimbursements for all brand, generic and specialty drugs, or products.

The allowance for brand and generic drugs compared the contracted guaranteed reimbursement rate to the ingredient cost of the brand and generic drugs. For this audit of Navitus, the ingredient cost allowance was determined using the Blue Book AWP from the MediSpan Drug Database or the pharmacy's U&C listed on the claim for the date each prescription was dispensed.

PillarRx also verified electronically that dispensing fees for each drug type, distribution channel and service fees (e.g., compound drug service fees) were paid in accordance with Navitus's contract.

Pricing and Fees Audit Findings

Pricing Findings

Navitus applied all adjudication methods for determining the correct allowance for prescriptions drugs by type and distribution method during the audit period. Adjudication methods are defined as the process by which a pharmacy submits prescription claims electronically when filling a prescription to ensure accurate pricing, copayments, and timely payment.

Dispensing Fee Findings

The dispensing fee calculated was the amount contractually agreed upon by the State and Navitus as the amount to be paid by the plan to the pharmacy for dispensing a prescription.

As shown in the following tables, for the State plan for period January 1, 2020 through December 31, 2020, the State was overcharged in dispensing fees. In contrast, for the period January 1, 2021 through December 31, 2021, the State was charged less than the contracted dispensing fee for the employee plan. For the Medicare plan the State was overcharged in dispensing fees for both periods between dates January 1, 2020 through December 31, 2021. Total calculated dispensing fees shown have been rounded to the nearest dollar.

***Note:** In the following chart, a **negative** variance indicates a higher than contracted dispensing fee collected. A **positive** variance indicates a lower than contracted dispensing fee collected.*

Employee Plan Dispensing Fees 01/01/2020 – 12/31/2020)					
Component Description	**Contracted Dispensing Fee**	**Number of Claims**	**Total Actual Dispensing Fee**	**Total Calculated Dispensing Fee**	**Total Overage/ (Shortfall)**
Retail Brand 0-30DS	$0.70	24,013	$0.68	$16,329.00	$480.00
Retail Generic 0-30DS	$0.70	136,826	$0.74	$101,251.00	($5,473.00)
Retail Brand 31+DS	$0.00	4,545	$0.02	$90.00	($90.00)
Retail Generic 31+DS	$0.00	68,382	$0.02	$1,368.00	(1,368.00)
Mail Brand	$0.00	871	$0.00	$0.00	$0.00
Mail Generic	$0.00	3,985	$0.00	$0.00	$0.00
TOTAL					**($6,451.00)**

Employee Plan Dispensing Fees (01/01/2021 – 12/31/2021)					
Component Description	**Contracted Dispensing Fee**	**Number of Claims**	**Total Actual Dispensing Fee**	**Total Calculated Dispensing Fee**	**Total Overage/ (Shortfall)**
Retail Brand 0-30DS	$0.68	31,703	$0.41	$12,999.00	$8,559.00
Retail Generic 0-30DS	$0.68	130,541	$0.65	$84,852.00	$3,916.00
Retail Brand 31+DS	$0.00	10,389	$0.02	$208.00	($208.00)
Retail Generic 31+DS	$0.00	70,584	$0.03	$2,118.00	($2,118.00)
Mail Brand	$0.00	834	$0.00	$0.00	$0.00
Mail Generic	$0.00	3,704	$0.00	$0.00	0.00
TOTAL					**$10,149.00**

Medicare Plan Dispensing Fees (01/01/2020 – 12/31/2020)					
Component Description	**Contracted Dispensing Fee**	**Number of Claims**	**Total Actual Dispensing Fee**	**Total Calculated Dispensing Fee**	**Total Overage/ (Shortfall)**
Retail Brand 0-30DS	$0.84	3,361	$1.24	$4,168.00	($1,345.00)
Retail Generic 0-30DS	$0.84	28,083	$1.51	$42,406.00	($18,816.00)
Retail Brand 31+DS	$0.00	2,214	$0.02	$45.00	($45.00)
Retail Generic 31+DS	$0.00	22,024	$0.03	$660.00	($660.00)
Mail Brand	$0.00	358	$0.00	$0.00	$0.00
Mail Generic	$0.00	3,302	$0.00	$0.00	$0.00
TOTAL					**($20,866.00)**

Medicare Plan Dispensing Fees (01/01/2021 – 12/31/2021)					
Component Description	**Contracted Dispensing Fee**	**Number of Claims**	**Total Actual Dispensing Fee**	**Total Calculated Dispensing Fee**	**Total Overage/ (Shortfall)**
Retail Brand 0-30DS	$0.82	2,934	$1.15	$3,374	($969.00)
Retail Generic 0-30DS	$0.82	24,288	$1.57	$38,132.00	($18,216.00)
Retail Brand 31+DS	$0.00	2,135	$0.03	$64.00	($64.00)
Retail Generic 31+DS	$0.00	21,318	$0.03	$639.00	($639.00)
Mail Brand	$0.00	354	$0.00	$0.00	$0.00
Mail Generic	$0.00	2,902	$0.00	$0.00	$0.00
TOTAL					**($19,888.00)**

RECONCILIATION OF PRICING GUARANTEES

Reconciliation of Pricing Guarantees Objective

The Reconciliation of Pricing Guarantees determined if the discount savings and other price controls with guaranteed performance levels in Navitus's contract with the State were met, and if not met, that accurate credit or payment was made to the State within the timeframe specified in the contract.

Reconciliation of Pricing Guarantees Scope

Using the terms of the State's contract with Navitus, we accumulated all prescription claims by type and distribution method for the period specified in the contract and balanced the total discount savings against the specified minimum discount guarantees. Similarly, all other performance guarantees were mapped against the actual prescription claims as adjudicated during the prescribed contract periods for performance guarantees. This reconciliation included the following contractual guarantees:

- AWP discounts applied for all drugs against third party pricing sources;
- MAC allowance for generic;
- Specialty drug allowance; and
- Dispensing fees.

Reconciliation of Pricing Guarantees Methodology

PillarRx used its proprietary AccuCAST® system to electronically compile total discount savings by silo (drug type and distribution method) and compare them to the contract guarantees in the Navitus contract. If Navitus's performance fell short of any of the guarantees, we validated that Navitus recognized the shortfall and credited or paid the difference to the State on a timely basis.

Reconciliation of Pricing Guarantees Findings

The following tables demonstrate our findings relative to pricing guarantees. Underperformance indicates the actual discounts obtained were less than guaranteed by the contract. Overperformance indicates the actual discounts obtained exceeded those guarantees by the contract.

Key	Over Performance *> Greater Than Contracted Rates*	Acceptable Performance *— Same as Contracted Rates*	Under-Performance *< Less Than Contracted Rates*

Employee Plan Discounts 01/01/2020 – 12/31/2020							
Component Description	**Number of Claims**	**Contracted Discount Rate**	**Actual Discount Rate**	**Contracted Claim Ingredient Cost**	**Actual Claim Ingredient Cost**	**Variance Total Overage/ (Shortfall)**	
Retail Brand 0-30DS	24,013	19.20%	18.84%	$7,412,260.72	$7,445,398.00	($33,137.28)	<
Retail Generic 0-30DS	136,826	85.00%	88.33%	$2,677,287.30	$2,083,620.00	$593,667.30	>
Retail Brand 31+DS	9,717	22.45%	23.47%	$5,845,492.55	$5,768,578.00	$76,914.55	>
Retail Generic 31+DS	68,382	87.50%	91.01%	$2,743,044.00	$1,973,607.00	$769,437.00	>
Mail Brand	871	24.00%	23.84%	$797,119.92	$798,794.00	($1,674.08)	<
Mail Generic	3,985	87.50%	88.67%	$185,725.63	$168,371.00	$17,354.63	>
Specialty	5,026	21.85%	21.33%	$29,584,339.74	$29,782,472.00	($198,132.26)	<
			TOTAL	**$49,245,269.86**	**$48,020,840.00**	**$1,224,429.86**	**>**

Medicare Plan Discounts 01/01/2020 – 12/31/2020							
Component Description	Number of Claims	Contracted Discount Rate	Actual Discount Rate	Contracted Claim Ingredient Cost	Actual Claim Ingredient Cost	Variance Total Overage/ (Shortfall)	
Retail Brand 0-30DS	3,361	18.15%	17.77%	$1,816,416.84	$1,824,751.00	($8,334.16)	<
Retail Generic 0-30DS	28,083	83.00%	84.20%	$574,860.10	$534,152.00	$40,708.10	>
Retail Brand 31+DS	2,214	21.45%	22.03%	$2,296,792.57	$2,279,832.00	$16,960.57	>
Retail Generic 31+DS	22,024	87.50%	88.99%	$846,017.25	$745,009.00	$101,008.25	>
Mail Brand	358	24.00%	23.98%	$379,674.72	$379,777.00	($102.28)	<
Mail Generic	3,302	87.50%	88.43%	$128,976.88	$119,396.00	$9,580.88	>
Specialty	740	21.85%	23.59%	$4,862,077.24	$4,753,858.00	$108,219.24	>
			TOTAL	**$10,904,815.60**	**$10,636,775.00**	**$268,040.60**	**>**

Employee Plan Discounts 01/01/2021 – 12/31/2021							
Component Description	Number of Claims	Contracted Discount Rate	Actual Discount Rate	Contracted Claim Ingredient Cost	Actual Claim Ingredient Cost	Variance Total Overage/ (Shortfall)	
Retail Brand 0-30DS	31,703	19.25%	19.71%	$7,220,510.77	$7,179,195.00	$41,315.77	>
Retail Generic 0-30DS	130,541	85.10%	89.27%	$2,656,327.30	$1,912,780.00	$743,547.30	>
Retail Brand 31+DS	10,389	22.50%	24.12%	$6,635,395.78	$6,496,371.00	$139,024.78	>
Retail Generic 31+DS	70,584	87.60%	91.60%	$2,869,636.02	$1,943,327.00	$926,309.02	>
Mail Brand	834	24.00%	23.84%	$772,718.60	$774,352.00	($1,633.40)	<
Mail Generic	3,704	87.60%	90.40%	$169,171.22	$130,947.00	$38,224.22	>
Specialty	5,327	21.85%	20.74%	$32,951,183.97	$33,419,367.00	($468,183.03)	<
			TOTAL	**$53,274,943.66**	**$51,856,339.00**	**$1,418,604.66**	**>**

Medicare Plan Discounts 01/01/2021 – 12/31/2021							
Component Description	Number of Claims	Contracted Discount Rate	Actual Discount Rate	Contracted Claim Ingredient Cost	Actual Claim Ingredient Cost	Variance Total Overage/ (Shortfall)	
Retail Brand 0-30DS	2,934	18.20%	17.95%	$1,649,451.19	$1,654,453.00	($5,001.81)	<
Retail Generic 0-30DS	24,288	83.10%	85.81%	$509,878.58	$427,978.00	$81,900.58	>
Retail Brand 31+DS	2,135	21.50%	22.30%	$2,343,955.84	$2,319,966.00	$23,989.83	>
Retail Generic 31+DS	21,318	87.60%	89.72%	$822,376.56	$681,485.00	$140,891.56	>
Mail Brand	354	24.00%	23.96%	$400,846.80	$401,053.00	($206.20)	<
Mail Generic	2,902	87.60%	90.21%	$118,065.11	$93,261.00	$24,804.11	>
Specialty	708	21.85%	26.59%	$5,142,057.43	$4,830,304.00	$311,753.43	>
			TOTAL	**$10,986,631.50**	**$10,408,500.00**	**$578,131.50**	**>**

In summary, when aggregating the dispensing fee calculations with the discounts achieved, PillarRx confirmed the overall overperformance self-reported by Navitus for Employee and Medicare plans for both audit periods. Further, PillarRx was able to confirm with the State that Navitus is allowed to offset underperformance in dispensing fees with an overperformance in discounts.

The State agreed a financial overage in one of the following areas: retail network, mail service and rebates can be used to offset a shortfall in another area. Based on the contractual terms between the State and Navitus to allow offsetting, no further actions are necessary.

The following table includes calculations completed by Pillar Rx and demonstrate the total AWP discounts achieved by Navitus for years 2020 and 2021 for both Employee and Medicare plans.

	PillarRx Combined Discounts and Dispensing Fee Guarantee Reconciliation	
Employee Plan	**2020**	**2021**
Discounts	$1,224,429.86	$1,418,605.00
Dispensing Fees	($6,451.00)	$10,149.00
Total Achieved	$1,217,979.00	$1,428,754.00
Total Missed	$0.00	$0.00
Amount Due to the State	$0.00	$0.00
Medicare Plan	**2020**	**2021**
Discounts	$268,040.60	$578,131.50
Dispensing Fees	($20,866.00)	($19,888.00)
Total Achieved	$247,174.00	$558,243.50
Total Missed	$0.00	$0.00
Amount Due to the State	$0.00	$0.00

BENEFIT PAYMENT ACCURACY REVIEW

Benefit Payment Accuracy Review Objective

The objective of the Benefit Payment Accuracy Review was to verify correct adjudication of plan design provisions and quantify potential opportunities for recovery and/or cost savings.

Benefit Payment Accuracy Review Scope

PillarRx created an exact model of the benefit plan parameters of the State ’s pharmacy plan in AccuCAST and systematically re-adjudicated 100% of paid prescription drugs.
Benefit plan parameters analyzed included, but were not limited to:

- Age and gender
- Copay/coinsurance
- Day supply maximums
- Excluded drugs
- Prior authorizations
- Quantity limits
- Refill limits
- Zero balance claims

Exceptions that were identified, but could not be explained by PillarRx’s benefit analysts, were provided to Navitus for explanation. When adequate documentation was provided to support exceptions were adjudicated correctly, AccuCAST was reset to represent the revised plan parameters and the claims were electronically re-adjudicated again to ensure consistency.

Benefit Payment Accuracy Review Methodology

After receiving the plan documentation from the State and Navitus including copayment and coverage rules and summary plan descriptions and/or plan documents, PillarRx programmed the State ’s plan design in AccuCAST. We have-adjudicated each claim and identified any exceptions. We aggregated the exceptions by category and our benefit analysts reviewed each category. Exceptions that could not be explained were submitted to Navitus for review.

PillarRx provided a sample of 147 Medicare and 96 Employee plan claims to Navitus for review and response. Our audit results were based upon those responses. Navitus’ responses will be made available upon request.

Benefit Payment Accuracy Review Findings

Copayments

Copayments represented the dollar amount required to be paid by the member when a prescription drug was purchased. Our observations and conclusions relative to copayment application for both the Employee and Medicare plans are shown in the following charts.

Employee Plan Copays 01/01/2020 – 12/31/2021				
Total Claims	**Copays per Plan**	**Copays Collected**	**Variance**	**Variance%**
516,975	$19,669,403.08	$19,669,403.08	$0.00	0%

Medicare Plan Copays 01/01/2020 – 12/31/2021				
Total Claims	**Copays per Plan**	**Copays Collected**	**Variance**	**Variance%**
115,925	$2,112,132.39	$2,112,132.39	$0.00	0%

Navitus was able to provide adequate explanation and documentation for each category of exception, which allowed PillarRx to conclude all copayments were applied correctly.

PillarRx agrees with Navitus' responses that copays adjudicated according to plan design specifications.

Drug Exclusions/Prior Authorizations
Exclusions specify the drugs and products that a plan would not cover unless there was a Prior Authorization (PA) on file. Based on documentation provided by the State, PillarRx created excluded drug and PA drug listings and re-adjudicated the claims for these non-covered and prior authorized medications.

The claim data and documentation provided by the State allowed PillarRx to confirm that drug exclusions and prior authorizations were administered correctly.

Administration of Age Rules
Age rules specify that a participant must be within a specific age group for a specific medication to be covered. PillarRx did find that there were 27 claims for Bowel Prep medications with no member copay for members over the age of 75. This medication is covered without cost sharing for ages 45-75. Navitus responded that these members did not have an age restriction for avoidance of copays in the Medicare plan formulary.

Administration of Quantity Limits
Quantity limits are included in plans to ensure safety and appropriate utilization. Based on the language in the drug coverage documents provided by Navitus, claims are adjudicating within the parameters.

J-CODE ANALYSIS

Specialty Drugs Medical and Pharmacy Data Analysis

As healthcare continues to evolve with new treatments and cures for complex and chronic diseases, managing treatment protocols and identifying cost-containment strategies is critical. Pharmacy costs are 20-30% of total healthcare spend with specialty drug treatments driving the narrative. While these medications have become life-changing, it is estimated that within the next few years, specialty medications will meet or exceed 55% of overall total pharmacy gross costs and will have the same impact in absolute dollars under the medical benefit.

PillarRx has designed an integrated, systematic approach to analyzing specialty medications paid under the pharmacy and medical benefit which delivers a complete clinical claim review in addition to a comprehensive financial analysis. PillarRx's analysis will:

1. Identify potential gaps that may exist within the program.
2. Facilitate the recovery of double payments if identified.
3. Assure specialty medications are being dosed and administered appropriately and at an optimal site of care.
4. Build a management framework with your medical vendor to mitigate future specialty drug spend while preserving member experience.

Data Forensics – Data Loading and Integration

For the initial set-up, PillarRx performs an extensive Quality Control process when loading the data points from both the pharmacy and medical vendors to assure the data integration is aligned accurately.

Medical Data Analysis

PillarRx's medical specialty drug analysis tool uses J-Codes as part of the Healthcare Common Procedure Coding System (HCPCS) Level II set of procedure codes. J-Codes are the codes used by the medical claim payer to price and process a claim, including the drug product and any additional fees that may be associated such as where the drug is administered, the provider professional fee, etc.

Pharmacy Data Analysis

PillarRx's pharmacy specialty drug analysis uses proprietary benchmarks and algorithms. A pharmacy vendor uses national Drug Code (NDC) numbers to pay a drug claim, and additional benchmarks are incorporated into the algorithms to understand dosing and duration to identify both clinical accuracy and potential waste with inefficiencies.

For the State, PillarRx reviewed both medical J-Code and pharmacy claim transactions for the audit period. A crosswalk between each medical and pharmacy claim was created by matching the employee ID and social security number along with the relationship code to the subscriber, the gender, and date of birth. Over 1,000 medications were reviewed in totality.

The following chart represents a comprehensive review of 100% of the State's specialty drug claims under both medical and pharmacy that will facilitate a strategic, long-term solution for managing your pharmacy spend.

Benefit Channel	Total Gross Claim Cost	Total Plan Cost *	Claim Count
Pharmacy	**$ 129,659,428.82**	**$ 107,877,892.75**	**632,900**
Medical			
Ambulance - Land	$ 13.60	$ 5.97	8
Ambulatory Surgical Center	$ 9,240.25	$ 8,186.96	20
Emergency Room – Hospital	$ 138,499.02	$ 100,659.44	2,174
Federally Qualified Health Center	$ 1,372.90	$ 1,353.58	10
Home	$ 3,581,283.83	$ 3,347,088.17	647
Inpatient Hospital	$ 59,659.46	$ 54,698.06	67
Office	$ 10,845,077.58	$ 9,309,671.28	6,616
On Campus-Outpatient Hospital	$ 19,716,085.52	$ 16,320,757.11	13,066
Rural Health Clinic	$ 8,882.19	$ 8,779.92	40
Telehealth	$ -	$ -	2
Urgent Care Facility	$ 287.32	$ 49.86	184
Hospital	$ 31,999.47	$ 15,966.90	57
Managed Care Pharmacy	$ 508.20	$ 181.50	7
Total Medical	**$ 34,392,909.34**	**$ 29,167,398.75**	**22,898**
Grand Total	**$ 164,052,338.16**	**$ 137,045,291.50**	**655,798**

**No member cost share included.*

PillarRx's analysis of these transactions provides:

- Financial understanding of the various delivery sites of care under the two benefit channels; a comparative analysis of J-Codes medical versus NDC pharmacy.
- Understanding of drug claim payments within the medical benefit, which may vary in cost based on where the medication is administered to the member, e.g., outpatient, medical office, infusion clinic, home, other or if moved to the pharmacy channel.
- Recommended policies/procedures for benefit coverage. Our analysis helps ensure payments meet specific prior authorization coverage criteria, dose management, and route of administration for medical and pharmacy claims.
- Improved rebate savings opportunities that may exists either by moving to a different benefit channel or maximizing existing rebates within current benefit channel vendor, typically discovered under medical
- Identification of medical/pharmacy claims overlap and duplication of payment. Our analysis looks for any concurrent 30-day period for a medical and prescription claim for the same medication.

Channel Benchmarks and Site of Care

PillarRx analyzes the medical and pharmacy claims data to:

- Identify differences in pricing (per unit) under both benefits.
- Identify the most appropriate delivery channel or point of access based on diagnosis/indication of drugs and by route of administration.
- Clinically assess medical necessity guidelines, business rules, and site of care delivery for both medical and pharmacy benefits.

This is followed by a high-level clinical review to assure each member is receiving an appropriate drug for an appropriate diagnosis for each medication filled. The review compares all specialty claims within each member's profile with an implied diagnosis for each medication. Within each implied diagnosis, PillarRx assures all utilization is appropriate by drug. Once confirmed, the next step is to review benefit channels and the specific site of service or care findings.

The parameters used for the findings are as follows:

- Exclude all oncology indications/medications.
- Ensure claim count based on 30-day supply (if filled for 90days, claim count equals three).
- Include specialty drug medications that were filled at two or more sites of administration.
- Include only specialty drug medications with cost averages greater than or equal to $500.
- Exclude if no actual or implied rebate information included with cost information.

The results of our analysis are included in the following charts. The information is based on the parameters defined above for both benefit channels including site of administration. Within sites of administration there are cost variances. The optimal opportunities are sorted accordingly by site of care and channel with the most cost-effective sites highlighted in yellow. Ambulatory surgical center sites, urgent care facilities, end stage renal facilities, emergency rooms, and other unknown facilities were not included in the comparison.

Findings – Optimal Benefit Channel/Site of Administration

PillarRx identified opportunities for potential savings if the State chose to direct members to a different channel and/or a different site of care within the same channel. Assuming 100% transition to the most favorable channel, there is a potential savings of approximately $11.5 million.

Two or More Channels or Sites of Care			
Optimal Site of Care	**Sum of Claim Count**	**Total Allowed Amount**	**Potential Movement Savings**
Home	654	$6,445,657.30	$1,567,806.98
Pharmacy	1,461	$1,708,580.14	$1,134,521.68
Medical Office	1,246	$7,125,509.66	$2,560,449.98
On-Campus Outpatient Hospital	2,381	$7,931,848.59	$2,861,805.80
Federally Qualified Health Center	672	$704,149.11	$301,653.81
Inpatient Hospital	271	$2,482,234.06	$1,951,991.36
Emergency Room	414	$1,044,203.07	$984,254.91
Ambulatory Surgical Center	483	$582,349.71	$191,464.71
TOTAL	**7,582**	**$28,024,531.64**	**$11,553,949.23**

A more detailed breakdown of the various channels follows.

HOME							
Diagnosis / Indication	**Medication**	**Site of Care**	**Total Allowed Amount**	**Sum of Claim Count**	**Utilizing Members**	**Average Allowed / Claim**	**Average Allowed / Utilizing Members**
Alpha-1 Deficiency	Alpha1-Proteinase Inhibitor (Human)	Home	$ 18,435.80	3	1	$ 6,145.27	$ 18,435.80
		Office	$ 40,887.02	2	1	$ 20,443.51	$ 40,887.02
		On Campus-Outpatient Hospital	$ 14,444.04	2	1	$ 7,222.02	$ 14,444.04
Asthma	Omalizumab	Home	$ 10,233.60	8	1	$ 1,279.20	$ 10,233.60
		Office	$ 754,509.62	256	17	$ 2,947.30	$ 44,382.92
		On Campus-Outpatient Hospital	$ 523,174.73	116	8	$ 4,510.13	$ 65,396.84
		Pharmacy	$ 56,359.32	18	6	$ 3,131.07	$ 9,393.22
Hemophilia	Emicizumab-kxwh	Home	$ 959,710.00	74	2	$ 12,969.05	$ 479,855.00
		Office	$ 18,650.00	1	1	$ 18,650.00	$ 18,650.00
Inflammatory Conditions	Ustekinumab (IV)	Home	$ 5,530.20	1	1	$ 5,530.20	$ 5,530.20
		Office	$ 297,085.50	16	2	$ 18,567.84	$ 148,542.75
		On Campus-Outpatient Hospital	$ 41,065.87	4	3	$ 10,266.47	$ 13,688.62
Multiple Sclerosis (MS)	Ocrelizumab	Home	$ 40,973.40	1	1	$ 40,973.40	$ 40,973.40
		Office	$ 2,175,192.47	53	16	$ 41,041.37	$ 135,949.53
		On Campus-Outpatient Hospital	$ 1,402,651.83	25	8	$ 56,106.07	$ 175,331.48
Thrombolytic	Alteplase	Emergency Room – Hospital	$ 49,272.83	4	4	$ 12,318.21	$ 12,318.21
		Home	$ 1,154.08	6	6	$ 192.35	$ 192.35
		Inpatient Hospital	$ 5,047.49	1	1	$ 5,047.49	$ 5,047.49
		Office	$ 10,901.37	15	3	$ 726.76	$ 3,633.79
		On Campus-Outpatient Hospital	$ 20,378.13	48	19	$ 424.54	$ 1,072.53
		Totals	**$ 6,445,657.30**	**654**		**$ 9,855.75**	
		Potential movement savings	**$ 1,567,806.98**				

PHARMACY							
Diagnosis / Indication	**Medication**	**Site of Care**	**Total Allowed Amount**	**Sum of Claim Count**	**Utilizing Members**	**Average Allowed / Claim**	**Average Allowed / Utilizing Members**
Asthma	Mepolizumab	Office	$ 66,672.00	20	2	$ 3,333.60	$ 33,336.00
		Pharmacy	$ 50,560.43	16	2	$ 3,160.03	$ 25,280.22
Asthma & Allergy	Benralizumab	Office	$ 129,756.54	24	2	$ 5,406.52	$ 64,878.27
		On Campus-Outpatient Hospital	$ 41,083.33	8	1	$ 5,135.42	$ 41,083.33
		Pharmacy	$ 107,766.46	21	4	$ 5,131.74	$ 26,941.62
Hemophilia	Desmopressin Acetate	Office	$ 42.92	1	1	$ 42.92	$ 42.92
		On Campus-Outpatient Hospital	$ 529.67	1	1	$ 529.67	$ 529.67
		Pharmacy	$ 2,784.10	81	28	$ 34.37	$ 99.43
Ophthalmic Conditions	Dexamethasone (Ophth)	Office	$ 27,274.81	18	6	$ 1,515.27	$ 4,545.80
		On Campus-Outpatient Hospital	$ 2,560.86	1	1	$ 2,560.86	$ 2,560.86
		Pharmacy	$ 148.18	2	3	$ 74.09	$ 49.39
Osteoporosis	Denosumab	Office	$ 284,723.21	116	38	$ 2,454.51	$ 7,492.72
		On Campus-Outpatient Hospital	$ 733,606.15	366	116	$ 2,004.39	$ 6,324.19
		Pharmacy	$ 1,200.79	1	1	$ 1,200.79	$ 1,200.79
Transplant	Cyclophosphamide	Office	$ 8,561.60	10	2	$ 856.16	$ 4,280.80
		On Campus-Outpatient Hospital	$ 113,813.91	87	16	$ 1,308.21	$ 7,113.37
		Pharmacy	$ 10,631.14	20	2	$ 531.56	$ 5,315.57
	Tacrolimus	Hospital	$ 6,424.92	7	1	$ 917.85	$ 6,424.92
		Pharmacy	$ 120,439.12	661	40	$ 182.21	$ 3,010.98
		Totals	**$ 1,708,580.14**	**1461**		**$ 1,169.46**	
		Potential movement savings	**$ 1,134,521.68**				

**Potential movement savings under the pharmacy site of care does not include rebates*

OFFICE							
Diagnosis / Indication	**Medication**	**Site of Care**	**Total Allowed Amount**	**Sum of Claim Count**	**Utilizing Members**	**Average Allowed / Claim**	**Average Allowed / Utilizing Members**
Blood Cell Deficiency	Darbepoetin Alfa	Emergency Room – Hospital	$ 775.11	2	3	$ 387.56	$ 258.37
		Office	$ 2,363.96	10	3	$ 236.40	$ 787.99
		On Campus-Outpatient Hospital	$ 226,492.74	210	13	$ 1,078.54	$ 17,422.52
Infection	Daptomycin	Home	$ 22,865.44	16	4	$ 1,429.09	$ 5,716.36
		Office	$ 10,711.00	51	3	$ 210.02	$ 3,570.33
		On Campus-Outpatient Hospital	$ 73,898.16	57	4	$ 1,296.46	$ 18,474.54
Inflammatory Conditions	Belimumab	Office	$ 294,072.80	111	4	$ 2,649.30	$ 73,518.20
		Pharmacy	$ 308,468.14	77	3	$ 4,006.08	$ 102,822.71
	Golimumab	Office	$ 54,887.16	32	4	$ 1,715.22	$ 13,721.79
		On Campus-Outpatient Hospital	$ 120,601.75	39	4	$ 3,092.35	$ 30,150.44
		Pharmacy	$ 126,327.60	25	1	$ 5,053.10	$ 126,327.60
	Infliximab	Home	$ 4,881.00	2	1	$ 2,440.50	$ 4,881.00
		Office	$ 203,014.64	91	10	$ 2,230.93	$ 20,301.46
		On Campus-Outpatient Hospital	$ 460,724.61	83	9	$ 5,550.90	$ 51,191.62
	Vedolizumab	Office	$ 405,735.70	59	9	$ 6,876.88	$ 45,081.74
		On Campus-Outpatient Hospital	$ 749,593.48	69	10	$ 10,863.67	$ 74,959.35
Miscellaneous Specialty Condition	Collagenase Clostridium Histolyticum	Office	$ 113,716.41	36	11	$ 3,158.79	$ 10,337.86
		On Campus-Outpatient Hospital	$ 15,806.38	3	2	$ 5,268.79	$ 7,903.19
	Eculizumab	Office	$ 27,657.60	1	1	$ 27,657.60	$ 27,657.60
		On Campus-Outpatient Hospital	$ 1,795,173.75	26	1	$ 69,045.14	$ 1,795,173.75
		Pharmacy	$ 630,125.40	22	1	$ 28,642.06	$ 630,125.40
	Naltrexone	Office	$ 2,975.33	3	1	$ 991.78	$ 2,975.33
		On Campus-Outpatient Hospital	$ 24,860.22	6	2	$ 4,143.37	$ 12,430.11
		Pharmacy	$ 14,522.79	14	9	$ 1,037.34	$ 1,613.64
Multiple Sclerosis (MS)	Natalizumab	Office	$ 420,123.00	56	4	$ 7,502.20	$ 105,030.75
		On Campus-Outpatient Hospital	$ 957,243.04	79	6	$ 12,117.00	$ 159,540.51
Osteoarthritis	Hyaluronan	Office	$ 29,631.97	53	30	$ 559.09	$ 987.73
		On Campus-Outpatient Hospital	$ 28,260.48	13	10	$ 2,173.88	$ 2,826.05
		Totals	**$ 7,125,509.66**	**1,246**		**$ 5,718.71**	
		Potential movement savings	**$ 2,560,449.98**				

ON CAMPUS-OUTPATIENT HOSPITAL							
Diagnosis / Indication	**Medication**	**Site of Care**	**Total Allowed Amount**	**Sum of Claim Count**	**Utilizing Members**	**Average Allowed / Claim**	**Average Allowed / Utilizing Members**
Blood Cell Deficiency	Filgrastim	Hospital	$ 12,603.35	12	2	$ 1,050.28	$ 6,301.68
		On Campus-Outpatient Hospital	$ 1,593.72	1	1	$ 1,593.72	$ 1,593.72
Blood Cell Deficiency	Pegfilgrastim	Office	$ 34,270.72	5	2	$ 6,854.14	$ 17,135.36
		On Campus-Outpatient Hospital	$ 345,388.61	56	18	$ 6,167.65	$ 19,188.26
Endometriosis (F) Oncology (M)	Leuprolide Acetate	Home	$ 23,355.23	2	2	$ 11,677.62	$ 11,677.62
		Office	$ 108,887.29	57	20	$ 1,910.30	$ 5,444.36
		On Campus-Outpatient Hospital	$ 94,491.86	93	29	$ 1,016.04	$ 3,258.34
Immune Deficiency	Immune Globulin (Human) IV	Emergency Room – Hospital	$ 8,255.20	1	1	$ 8,255.20	$ 8,255.20
		Office	$ 305,049.17	64	7	$ 4,766.39	$ 43,578.45
		On Campus-Outpatient Hospital	$ 408,140.38	160	8	$ 2,550.88	$ 51,017.55
	Immune Globulin (Human) IV or Subcutaneous	Office	$ 449,777.66	108	4	$ 4,164.61	$ 112,444.42
		On Campus-Outpatient Hospital	$ 191,994.82	58	2	$ 3,310.26	$ 95,997.41
		Pharmacy	$ 520,542.98	55	3	$ 9,464.42	$ 173,514.33
Inflammatory Conditions	Abatacept	Office	$ 10,342.00	2	1	$ 5,171.00	$ 10,342.00
		On Campus-Outpatient Hospital	$ 69,969.82	23	1	$ 3,042.17	$ 69,969.82
		Pharmacy	$ 1,334,188.79	285	15	$ 4,681.36	$ 88,945.92
	Certolizumab Pegol	On Campus-Outpatient Hospital	$ 113,337.59	49	2	$ 2,313.01	$ 56,668.80
		Pharmacy	$ 1,343,550.72	261	19	$ 5,147.70	$ 70,713.20
	Tocilizumab	Office	$ 5,994.11	2	2	$ 2,997.06	$ 2,997.06
		On Campus-Outpatient Hospital	$ 298,675.45	183	7	$ 1,632.11	$ 42,667.92
		Pharmacy	$ 1,011,677.76	259	12	$ 3,906.09	$ 84,306.48
Miscellaneous Specialty Condition	IncobotulinumtoxinA	Office	$ 1,728.00	1	1	$ 1,728.00	$ 1,728.00
		On Campus-Outpatient Hospital	$ 441.62	3	1	$ 147.21	$ 441.62
Ophthalmic Conditions	Aflibercept	Office	$ 1,001,763.52	435	53	$ 2,302.90	$ 18,901.20
		On Campus-Outpatient Hospital	$ 45,390.37	31	5	$ 1,464.21	$ 9,078.07
Osteoarthritis	Hylan	Office	$ 70,084.97	99	53	$ 707.93	$ 1,322.36
		On Campus-Outpatient Hospital	$ 6,543.07	14	8	$ 467.36	$ 817.88
Osteoporosis	Romosozumab-aqqg	Emergency Room – Hospital	$ 1,954.26	1	1	$ 1,954.26	$ 1,954.26
		Office	$ 68,512.50	32	3	$ 2,141.02	$ 22,837.50
		On Campus-Outpatient Hospital	$ 43,343.05	29	3	$ 1,494.59	$ 14,447.68
		Totals	**$ 7,931,848.59**	**2381**		**$ 3,331.31**	
		Potential movement savings	**$ 2,861,805.80**				

INPATIENT HOSPITAL							
Diagnosis / Indication	**Medication**	**Site of Care**	**Total Allowed Amount**	**Sum of Claim Count**	**Utilizing Members**	**Average Allowed / Claim**	**Average Allowed / Utilizing Members**
Cystic Fibrosis	Dornase Alfa	Inpatient Hospital	$ 1,318.20	1	1	$ 1,318.20	$ 1,318.20
		Pharmacy	$ 84,692.74	17	3	$ 4,981.93	$ 28,230.91
Hemophilia	Antihemophilic Factor (Recombinant) Pegylated	Home	$ 1,161,009.03	70	1	$ 16,585.84	$ 1,161,009.03
		Inpatient Hospital	$ 51,871.87	8	1	$ 6,483.98	$ 51,871.87
Immune Deficiency	Immune Globulin (Human) Subcutaneous	Emergency Room – Hospital	$ 39.54	4	1	$ 9.89	$ 39.54
		Home	$ 881,841.73	119	3	$ 7,410.43	$ 293,947.24
		Inpatient Hospital	$ 4.47	1	1	$ 4.47	$ 4.47
		Office	$ 248,394.44	13	4	$ 19,107.26	$ 62,098.61
		On Campus-Outpatient Hospital	$ 285.14	3	2	$ 95.05	$ 142.57
		Pharmacy	$ 52,776.90	35	3	$ 1,507.91	$ 17,592.30
		Totals	**$ 2,482,234.06**	**271**		**$ 9,159.54**	
		Potential movement savings	**$ 1,951,991.36**				

EMERGENCY ROOM-HOSPITAL							
Diagnosis / Indication	**Medication**	**Site of Care**	**Total Allowed Amount**	**Sum of Claim Count**	**Utilizing Members**	**Average Allowed / Claim**	**Average Allowed / Utilizing Members**
Endocrine Disorder	Octreotide Acetate	Emergency Room – Hospital	$ 2,324.06	7	4	$ 332.01	$ 581.02
		On Campus-Outpatient Hospital	$ 439,635.52	66	5	$ 6,661.14	$ 87,927.10
		Pharmacy	$ 493,822.96	92	4	$ 5,367.64	$ 123,455.74
Transplant	Mycophenolate Sodium	Emergency Room – Hospital	$ 20.75	1	1	$ 20.75	$ 20.75
		Home	$ 19,047.50	35	5	$ 544.21	$ 3,809.50
		Hospital	$ 10,723.68	23	3	$ 466.25	$ 3,574.56
		Pharmacy	$ 78,628.60	190	20	$ 413.83	$ 3,931.43
		Totals	**$ 1,044,203.07**	**414**		**$ 2,522.23**	
		Potential movement savings	**$ 984,254.91**				

AMBULATORY SURGICAL Center							
Diagnosis / Indication	**Medication**	**Site of Care**	**Total Allowed Amount**	**Sum of Claim Count**	**Utilizing Members**	**Average Allowed / Claim**	**Average Allowed / Utilizing Members**
Miscellaneous Specialty Condition	OnabotulinumtoxinA	Ambulatory Surgical Center	$ 5,665.00	7	6	$ 809.29	$ 944.17
		Office	$ 456,992.37	412	91	$ 1,109.20	$ 5,021.89
		On Campus-Outpatient Hospital	$ 119,692.34	64	26	$ 1,870.19	$ 4,603.55
		Totals	**$ 582,349.71**	**483**		**$ 1,205.69**	
		Potential movement savings	**$ 191,464.71**				

FEDERALLY QUALIFIED HEALTH CENTER							
Diagnosis / Indication	**Medication**	**Site of Care**	**Total Allowed Amount**	**Sum of Claim Count**	**Utilizing Members**	**Average Allowed / Claim**	**Average Allowed / Utilizing Members**
Contraception	Copper (IUD)	Federally Qualified Health Center	$ 264.00	1	1	$ 264.00	$ 264.00
		Home	$ 509.61	1	1	$ 509.61	$ 509.61
		Office	$ 34,744.36	51	49	$ 681.26	$ 709.07
		Pharmacy	$ 1,753.12	2	2	$ 876.56	$ 876.56
Contraception	Etonogestrel	Federally Qualified Health Center	$ 339.15	1	1	$ 339.15	$ 339.15
		Office	$ 161,306.09	163	160	$ 989.61	$ 1,008.16
		On Campus-Outpatient Hospital	$ 2,434.94	2	3	$ 1,217.47	$ 811.65
		Pharmacy	$ 14,629.90	14	19	$ 1,044.99	$ 769.99
		Rural Health Clinic	$ 4,004.78	2	2	$ 2,002.39	$ 2,002.39
Contraception	Levonorgestrel (IUD)	Ambulatory Surgical Center	$ 3,312.45	4	4	$ 828.11	$ 828.11
		Federally Qualified Health Center	$ 750.00	1	1	$ 750.00	$ 750.00
		Office	$ 431,846.61	383	379	$ 1,127.54	$ 1,139.44
		On Campus-Outpatient Hospital	$ 16,677.65	15	15	$ 1,111.84	$ 1,111.84
		Pharmacy	$ 26,898.36	28	30	$ 960.66	$ 896.61
		Rural Health Clinic	$ 4,678.09	4	4	$ 1,169.52	$ 1,169.52
		Totals	**$ 704,149.11**	**672**		**$ 1,047.84**	

One Channel or Site of Care

The following tables are based on specialty drugs where only one channel or site of service was identified because there is no other channel for comparison.

No additional opportunities for savings have been identified for the following specialty medications but the analysis shows the total allowed and site of care.

Site of Care	Total Allowed	Claim Count
Emergency Room – Hospital	$22,148.06	4
Home	$404,902.44	75
Office	$123,825.59	349
On Campus-Outpatient Hospital	$414,960.77	160
Pharmacy	$75,824,274.37	25,394
TOTAL	**$76,790,111.23**	**25,982**

Key							
Route of Admin Descriptions							
IJ	Injectable	IN	Intranasal	SC	Subcutaneous	OR	Oral
IM	Intramuscular	IX	Injection Into a Joint	VA	Vaginal	IV	Intravenous

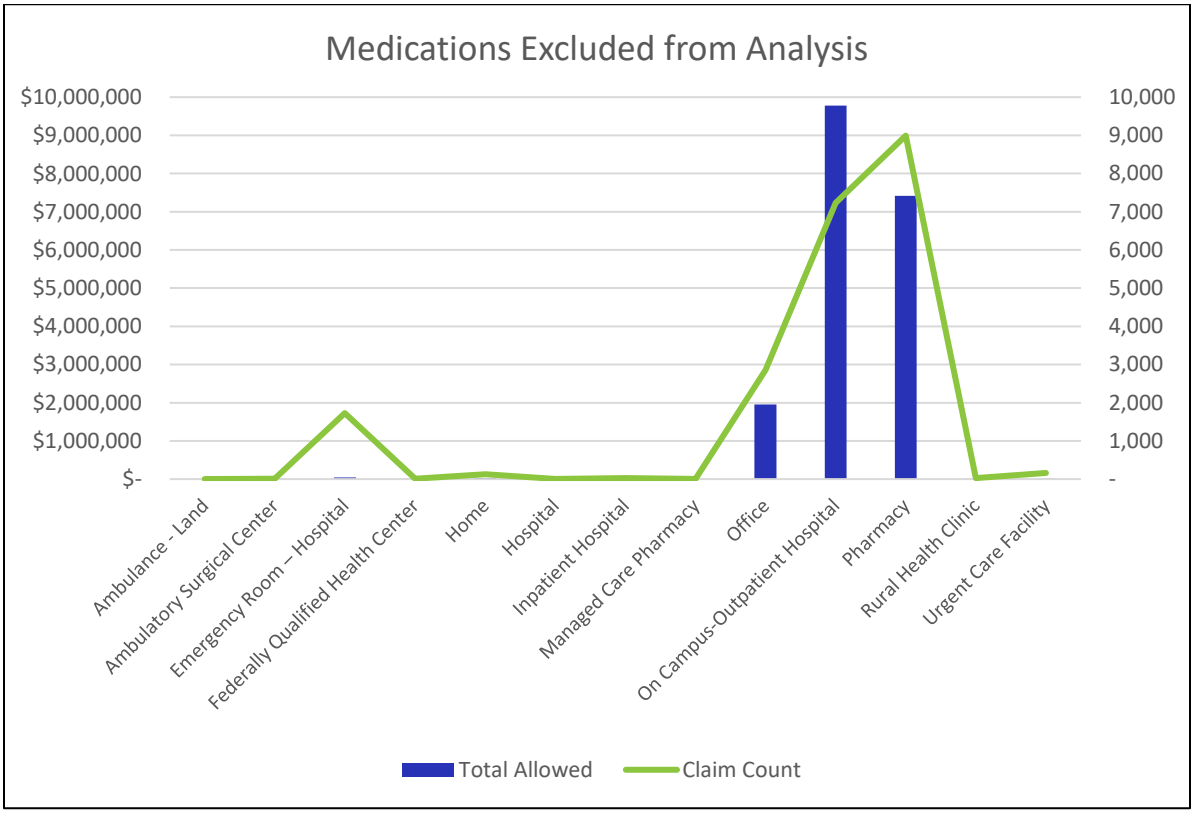
Site of Care	Diagnosis / Indication	Medication	Route of Admin	Total Allowed Amount	Sum of Claim Count	Utilizing Members	Average Allowed / Claim	Average Allowed / Utilizing Members
Emergency Room – Hospital	Hereditary Angioedema	C1 Esterase Inhibitor (Human)	IV	$ 21,956.79	3	2	$ 7,318.93	$ 10,978.40
	Miscellaneous Diseases	Methylnaltrexone Bromide	IJ	$ 191.27	1	1	$ 191.27	$ 191.27
Home	Hemophilia	Antihemophilic Factor (Recombinant Porcine) (rpFVI	IJ	$ 10,962.00	1	1	$ 10,962.00	$ 10,962.00
	Hemophilia	Antihemophilic Factor (Recombinant) (rFVIII)	IV	$ 15,729.73	6	1	$ 2,621.62	$ 15,729.73
	Hemophilia	Antihemophilic Factor (Recombinant) Single Chain	IJ	$ 5,450.02	3	2	$ 1,816.67	$ 2,725.01
	Muscular Dystrophy	Edaravone	IJ	$ 349,220.80	28	1	$ 12,472.17	$ 349,220.80
	Transplant	Sirolimus (Bulk)	OR	$ 7,819.89	34	1	$ 230.00	$ 7,819.89
	Miscellaneous Specialty Condit	Ziconotide Acetate	IJ	$ 15,720.00	3	1	$ 5,240.00	$ 15,720.00

Site of Care	Diagnosis / Indication	Medication	Route of Admin	Total Allowed Amount	Sum of Claim Count	Utilizing Members	Average Allowed / Claim	Average Allowed / Utilizing Members
Office	Osteoarthritis	Cross-Linked Hyaluronate	IX	$ 9,860.79	11	9	$ 896.44	$ 1,095.64
	Miscellaneous Specialty Condit	Hydroxyprogesterone Caproate (Antineoplastic)	IJ	$ 3,920.64	3	1	$ 1,306.88	$ 3,920.64
	Ophthalmic Conditions	Ranibizumab	IZ	$ 65,754.99	41	5	$ 1,603.78	$ 13,151.00
	Osteoarthritis	Sodium Hyaluronate (Viscosupplement)	IX	$ 44,289.17	294	63	$ 150.64	$ 703.00
On Campus-Outpatient Hospital	Miscellaneous Specialty Condit	AbobotulinumtoxinA	IM	$ 19,791.40	8	2	$ 2,473.93	$ 9,895.70
	Hemophilia	Antihemophilic Factor/von Willebrand Factor Comple	IV	$ 26,967.15	1	1	$ 26,967.15	$ 26,967.15
	Transplant	Belatacept	IV	$ 70,504.60	87	2	$ 810.40	$ 35,252.30
	Endocrine Disorder	Lanreotide Acetate	SC	$ 280,454.61	41	3	$ 6,840.36	$ 93,484.87
	Blood Cell Deficiency	Methoxy Polyethylene Glycol-Epoetin Beta	SC	$ 4,827.54	14	3	$ 344.82	$ 1,609.18
	Blood Cell Deficiency	Romiplostim	SC	$ 8,076.88	3	1	$ 2,692.29	$ 8,076.88
	Blood Cell Deficiency	Tbo-Filgrastim	SC	$ 4,338.59	6	2	$ 723.10	$ 2,169.30
Pharmacy	Inflammatory Conditions	Adalimumab	SC	$ 21,907,646.52	3,467	126	$ 6,318.91	$ 173,870.21
	Hypercholesterolemia	Alirocumab	SC	$ 35,637.19	84	5	$ 424.25	$ 7,127.44
	Antiviral	Amantadine HCl	OR	$ 4,536.60	191	24	$ 23.75	$ 189.03
	Pulmonary Hypertension	Ambrisentan	OR	$ 165,508.77	16	1	$ 10,344.30	$ 165,508.77
	Inflammatory Conditions	Anakinra	SC	$ 31,072.38	7	1	$ 4,438.91	$ 31,072.38
	Inflammatory Conditions	Apremilast	OR	$ 2,610,984.24	727	39	$ 3,591.45	$ 66,948.31
	Inflammatory Conditions	Baricitinib	OR	$ 233,863.34	103	7	$ 2,270.52	$ 33,409.05
	HIV	Bictegravir-Emtricitabine-Tenofovir Alafenamide Fu	OR	$ 456,216.53	144	9	$ 3,168.17	$ 50,690.73
	Ophthalmic Conditions	Bimatoprost	OP	$ 158,404.78	775	74	$ 204.39	$ 2,140.61
	Miscellaneous Diseases	Buprenorphine	SC, TD	$ 19,317.15	82	17	$ 235.58	$ 1,136.30
	Miscellaneous Diseases	Buprenorphine HCl	BU, SL	$ 4,263.69	127	11	$ 33.57	$ 387.61
	Miscellaneous Specialty Condit	Carbidopa-Levodopa	OR	$ 62,276.14	1,154	74	$ 53.97	$ 841.57
	Infertility	Chorionic Gonadotropin	IM	$ 35,373.86	39	1	$ 907.02	$ 35,373.86
	Renal Disorder	Cinacalcet HCl	OR	$ 28,630.69	99	8	$ 289.20	$ 3,578.84
	Multiple Sclerosis (MS)	Cladribine (Multiple Sclerosis)	OR	$ 162,074.10	2	1	$ 81,037.05	$ 162,074.10
	Transplant	Cyclosporine	OR	$ 8,673.27	31	7	$ 279.78	$ 1,239.04
	Transplant	Cyclosporine Modified (For Microemulsion)	OR	$ 16,481.01	97	15	$ 169.91	$ 1,098.73
	Multiple Sclerosis (MS)	Dalfampridine	OR	$ 9,166.30	111	11	$ 82.58	$ 833.30
	HIV	Darunavir-Cobicistat	OR	$ 50,411.30	26	2	$ 1,938.90	$ 25,205.65
	Iron Toxicity	Deferasirox	OR	$ 102,429.45	17	1	$ 6,025.26	$ 102,429.45
	Muscular Dystrophy	Deflazacort	OR	$ 92,713.94	24	1	$ 3,863.08	$ 92,713.94
	Hemophilia	Desmopressin Acetate Spray	NA	$ 2,885.66	37	4	$ 77.99	$ 721.42
	Hemophilia	Desmopressin Acetate Spray Refrigerated	NA	$ 1,601.24	15	1	$ 106.75	$ 1,601.24
	Multiple Sclerosis (MS)	Dimethyl Fumarate	OR	$ 260,620.10	69	4	$ 3,777.10	$ 65,155.03
	Multiple Sclerosis (MS)	Diroximel Fumarate	OR	$ 14,658.62	2	1	$ 7,329.31	$ 14,658.62
	HIV	Dolutegravir Sodium	OR	$ 7,380.92	4	1	$ 1,845.23	$ 7,380.92
	Asthma & Allergy	Dupilumab	SC	$ 1,847,639.38	589	28	$ 3,136.91	$ 65,987.12
	HIV	Efavirenz-Emtricitabine-Tenofovir Disoproxil Fumar	OR	$ 33,334.68	12	1	$ 2,777.89	$ 33,334.68
	Cystic Fibrosis	Elexacaftor-Tezacaftor-Ivacaftor	OR	$ 1,164,808.67	49	4	$ 23,771.61	$ 291,202.17
	Blood Cell Deficiency	Eltrombopag Olamine	OR	$ 214,144.62	36	2	$ 5,948.46	$ 107,072.31
	HIV	Elvitegravir-Cobicistat-Emtricitabine-Tenofovir Al	OR	$ 6,541.54	2	1	$ 3,270.77	$ 6,541.54
	HIV	Emtricitabine-Tenofovir Alafenamide Fumarate	OR	$ 7,434.84	4	1	$ 1,858.71	$ 7,434.84
	HIV	Emtricitabine-Tenofovir Disoproxil Fumarate	OR	$ 285,661.71	275	28	$ 1,038.77	$ 10,202.20
	Hepatitis B	Entecavir	OR	$ 517.37	24	2	$ 21.56	$ 258.69
	Miscellaneous Specialty Condit	Erenumab-aooe	SC	$ 191,787.24	328	28	$ 584.72	$ 6,849.54
	Inflammatory Conditions	Etanercept	SC	$ 7,502,844.31	1,376	77	$ 5,452.65	$ 97,439.54
	Transplant	Everolimus (Immunosuppressant)	OR	$ 5,333.62	6	2	$ 888.94	$ 2,666.81
	Hypercholesterolemia	Evolocumab	SC	$ 84,044.95	197	18	$ 426.62	$ 4,669.16
	Miscellaneous Specialty Condit	Fentanyl	TD	$ 39,218.96	531	48	$ 73.86	$ 817.06
	Blood Cell Deficiency	Filgrastim-sndz	IJ	$ 9,656.07	7	5	$ 1,379.44	$ 1,931.21
	Multiple Sclerosis (MS)	Fingolimod HCl	OR	$ 2,854,350.16	331	13	$ 8,623.41	$ 219,565.40
	Miscellaneous Specialty Condit	Fremanezumab-vfrm	SC	$ 21,689.57	36	4	$ 602.49	$ 5,422.39
	Miscellaneous Specialty Condit	Galcanezumab-gnlm	SC	$ 289,202.07	457	47	$ 632.83	$ 6,153.24
	Multiple Sclerosis (MS)	Glatiramer Acetate	SC	$ 1,942,491.59	658	23	$ 2,952.11	$ 84,456.16

Site of Care	Diagnosis / Indication	Medication	Route of Admin	Total Allowed Amount	Sum of Claim Count	Utilizing Members	Average Allowed / Claim	Average Allowed / Utilizing Members
Pharmacy	Hepatitis C	Glecaprevir-Pibrentasvir	OR	$ 154,355.45	12	6	$ 12,862.95	$ 25,725.91
	Inflammatory Conditions	Guselkumab	SC	$ 2,203,023.51	194	11	$ 11,355.79	$ 200,274.86
	Miscellaneous Specialty Condit	Hydrocortisone	OR	$ 5,400.86	285	32	$ 18.95	$ 168.78
	Miscellaneous Diseases	Hydroxyurea (Sickle Cell Disease)	OR	$ 289.74	13	1	$ 22.29	$ 289.74
	Osteoporosis	Ibandronate Sodium	OR	$ 4,000.60	471	41	$ 8.49	$ 97.58
	Multiple Sclerosis (MS)	Interferon Beta-1a	IM, SC	$ 2,774,830.02	369	11	$ 7,519.86	$ 252,257.27
	Multiple Sclerosis (MS)	Interferon Beta-1b	SC	$ 15,951.14	2	1	$ 7,975.57	$ 15,951.14
	Infection	Isavuconazonium Sulfate	OR	$ 42,779.70	9	1	$ 4,753.30	$ 42,779.70
	Inflammatory Conditions	Ixekizumab	SC	$ 2,485,368.54	347	30	$ 7,162.45	$ 82,845.62
	Pulmonary Hypertension	Macitentan	OR	$ 145,037.14	14	1	$ 10,359.80	$ 145,037.14
	Infection	Mechlorethamine HCl (Topical)	EX	$ 53,087.55	11	1	$ 4,826.14	$ 53,087.55
	Inflammatory Conditions	Mercaptopurine	OR	$ 11,568.92	42	3	$ 275.45	$ 3,856.31
	Pulmonary Hypertension	Nintedanib Esylate	OR	$ 149,860.04	14	1	$ 10,704.29	$ 149,860.04
	Blood Cell Deficiency	Pegfilgrastim-cbqv	SC	$ 12,153.72	3	1	$ 4,051.24	$ 12,153.72
	Blood Cell Deficiency	Pegfilgrastim-jmdb	SC	$ 4,051.24	1	1	$ 4,051.24	$ 4,051.24
	Multiple Sclerosis (MS)	Peginterferon Beta-1a	SC	$ 348,756.38	50	1	$ 6,975.13	$ 348,756.38
	Miscellaneous Specialty Condit	Pimavanserin Tartrate	OR	$ 7,312.38	2	1	$ 3,656.19	$ 7,312.38
	Pulmonary Hypertension	Pirfenidone	OR	$ 769,096.81	86	6	$ 8,942.99	$ 128,182.80
	Infection	Posaconazole	OR	$ 7,035.22	2	2	$ 3,517.61	$ 3,517.61
	Contraception	Progesterone	IM	$ 15,823.82	862	172	$ 18.36	$ 92.00
	Infertility	Progesterone (Vaginal)	VA	$ 1,115.59	4	2	$ 278.90	$ 557.80
	Miscellaneous Specialty Condit	Propranolol HCl	OR	$ 85,159.78	5,797	800	$ 14.69	$ 106.45
	HIV	Raltegravir Potassium	OR	$ 2,163.74	2	4	$ 1,081.87	$ 540.94
	Amyotrophic lateral sclerosis (A	Riluzole	OR	$ 1,591.87	40	4	$ 39.80	$ 397.97
	Pulmonary Hypertension	Riociguat	OR	$ 559,099.68	48	2	$ 11,647.91	$ 279,549.84
	Inflammatory Conditions	Risankizumab-rzaa	SC	$ 3,046,295.32	190	23	$ 16,033.13	$ 132,447.62
	Miscellaneous Specialty Condit	Rotigotine	TD	$ 10,660.61	16	2	$ 666.29	$ 5,330.31
	Inflammatory Conditions	Sarilumab	SC	$ 122,257.12	34	1	$ 3,595.80	$ 122,257.12
	Inflammatory Conditions	Secukinumab	SC	$ 3,193,103.30	593	36	$ 5,384.66	$ 88,697.31
	Erectile Dysfunction	Sildenafil Citrate	OR	$ 954.76	144	22	$ 6.63	$ 43.40
	Pulmonary Hypertension	Sildenafil Citrate (Pulmonary Hypertension)	OR	$ 12,772.37	153	14	$ 83.48	$ 912.31
	Transplant	Sirolimus	OR	$ 36,348.13	111	3	$ 327.46	$ 12,116.04
	Miscellaneous Specialty Condit	Sodium Oxybate	OR	$ 425,527.47	25	1	$ 17,021.10	$ 425,527.47
	Hepatitis C	Sofosbuvir-Velpatasvir	OR	$ 23,257.80	3	1	$ 7,752.60	$ 23,257.80
	Growth Deficiency	Somatropin	IJ, SC	$ 606,015.80	250	7	$ 2,424.06	$ 86,573.69
	Erectile Dysfunction	Tadalafil	OR	$ 3,313.73	315	23	$ 10.52	$ 144.08
	Infection	Tedizolid Phosphate	OR	$ 2,320.56	1	1	$ 2,320.56	$ 2,320.56
	Miscellaneous Specialty Condit	Telotristat Etiprate	OR	$ 110,858.29	15	1	$ 7,390.55	$ 110,858.29
	Hepatitis B	Tenofovir Alafenamide Fumarate	OR	$ 24,429.48	21	2	$ 1,163.31	$ 12,214.74
	Multiple Sclerosis (MS)	Teriflunomide	OR	$ 4,234,761.72	542	19	$ 7,813.21	$ 222,882.20
	Osteoporosis	Teriparatide (Recombinant)	SC	$ 810,733.51	226	19	$ 3,587.32	$ 42,670.18
	Endocrine Disorder	Testosterone	IL, TD	$ 81,075.53	486	45	$ 166.82	$ 1,801.68
	Cystic Fibrosis	Tobramycin	IN	$ 3,978.31	3	1	$ 1,326.10	$ 3,978.31
	Inflammatory Conditions	Tofacitinib Citrate	OR	$ 2,064,078.38	438	25	$ 4,712.51	$ 82,563.14
	Miscellaneous Specialty Condit	Tolvaptan	OR	$ 516,116.77	33	3	$ 15,639.90	$ 172,038.92
	Hemophilia	Tranexamic Acid	OR	$ 1,465.21	25	18	$ 58.61	$ 81.40
	Inflammatory Conditions	Upadacitinib	OR	$ 1,328,760.07	271	19	$ 4,903.17	$ 69,934.74
	Inflammatory Conditions	Ustekinumab	SC	$ 6,312,524.46	391	29	$ 16,144.56	$ 217,673.26
	Transplant	Valganciclovir HCl	OR	$ 10,223.09	60	17	$ 170.38	$ 601.36
		Totals		**$ 76,790,111.23**	**25,982**			

Medications Excluded from Analysis

There were several medications that fell outside of all parameters. The following chart is showing those that did not meet specialty criteria and were therefore not considered for the analysis. Many drugs in this category include oncology and/or lower cost medications.



Rebate Savings Opportunities

Identification of Appropriate Delivery Channel

PillarRx prepared a comparative analysis between actual medical claims and pharmacy claim data for the same Generic Product Indicator (GPI) to demonstrate the advantage of moving drugs from the medical benefit to the pharmacy benefit. The following parameters were applied:

- For the medical claims we are assuming a 30-day supply to compare to pharmacy claims with a 30-day supply.
- PillarRx uses a standard specialty rebate amount of $450 to calculate the potential rebate per specialty brand claims.
- The total savings calculated assumes a 100% movement of the drug from the medical benefit to the pharmacy benefit channel. An estimated $2.6 million over the entire time span of the audit combining both the Employee and Medicare plans would be the calculated rebate dollars.

Upon completion of this report, the State informed PillarRx that some site of care savings and improved rebate opportunities have already been implemented with the State's medical plan administrator.

Indication	Brand Name	Short Description	Medical Claim Count	Average Medical Allowed Amount	Total Allowed Amount	Potential Rebate ($450/ prescription)
Alpha-1 Deficiency	Alpha1-Proteinase Inhibitor (H	Alpha1-Proteinase Inhibitor (Human)	7	$ 10,538.12	$ 73,766.86	$ 3,150.00
Asthma	NUCALA	Mepolizumab	20	$ 3,333.60	$ 66,672.00	$ 9,000.00
	XOLAIR	Omalizumab	380	$ 3,389.26	$ 1,287,917.95	$ 171,000.00
Asthma & Allergy	FASENRA	Benralizumab	32	$ 5,338.75	$ 170,839.87	$ 14,400.00
Blood Cell Deficiency	ARANESP	Darbepoetin Alfa	222	$ 1,034.38	$ 229,631.81	$ 99,900.00
	NEUPOGEN, GRANIX, ZARXIO	Filgrastim	13	$ 1,092.08	$ 14,197.07	$ 5,850.00
	NEULASTA	Pegfilgrastim	61	$ 6,223.92	$ 379,659.33	$ 27,450.00
	NPLATE	Romiplostim	3	$ 2,692.29	$ 8,076.88	$ 1,350.00
	GRANIX	Tbo-Filgrastim	6	$ 723.10	$ 4,338.59	$ 2,700.00
Chemotherapy side effect reducer	Aprepitant	Aprepitant	253	$ 694.07	$ 175,600.21	$ 113,850.00
	EMEND	Fosaprepitant Dimeglumine	100	$ 539.85	$ 53,985.48	$ 45,000.00
Contraception	PARAGARD	Copper (IUD)	53	$ 670.15	$ 35,517.97	$ 23,850.00
	IMPLANON, NEXPLANON	Etonogestrel	168	$ 1,000.51	$ 168,084.96	$ 75,600.00
	KYLEENA, LILETTA, MIRENA, SK	Levonorgestrel (IUD)	407	$ 1,123.50	$ 457,264.80	$ 183,150.00
Cystic Fibrosis	Dornase Alfa	Dornase Alfa	1	$ 1,318.20	$ 1,318.20	$ 450.00
Endocrine Disorder	Lanreotide Acetate	Lanreotide Acetate	41	$ 6,840.36	$ 280,454.61	$ 18,450.00
	OCTREOTIDE ACETATE	Octreotide Acetate	73	$ 6,054.24	$ 441,959.58	$ 32,850.00
Endometriosis (F) Oncology (M)	LUPRON DEPOT, ELIGARD	Leuprolide Acetate	152	$ 1,491.67	$ 226,734.38	$ 68,400.00
Hemophilia	Antihemophilic Factor (Recom	Antihemophilic Factor (Recombinant Porcine) (r	1	$ 10,962.00	$ 10,962.00	$ 450.00
	Antihemophilic Factor (Recom	Antihemophilic Factor (Recombinant) (rFVIII)	6	$ 2,621.62	$ 15,729.73	$ 2,700.00
	Antihemophilic Factor (Recom	Antihemophilic Factor (Recombinant) Pegylated	78	$ 15,549.76	$ 1,212,880.90	$ 35,100.00
	Antihemophilic Factor (Recom	Antihemophilic Factor (Recombinant) Single Cha	3	$ 1,816.67	$ 5,450.02	$ 1,350.00
	FACTOR VIII	Antihemophilic Factor/von Willebrand Factor Co	1	$ 26,967.15	$ 26,967.15	$ 450.00
	Emicizumab-kxwh	Emicizumab-kxwh	75	$ 13,044.80	$ 978,360.00	$ 33,750.00
	Tenecteplase	Tenecteplase	1	$ 11,880.00	$ 11,880.00	$ 450.00
Hereditary Angioedema	C1 Esterase Inhibitor (Human)	C1 Esterase Inhibitor (Human)	3	$ 7,318.93	$ 21,956.79	$ 1,350.00
Immune Deficiency	GAMMAPLX, PRIVIGEN, OCTAG	Immune Globulin (Human) IV	225	$ 3,206.42	$ 721,444.75	$ 101,250.00
	GAMUNEX LIQUID, GAMUNEX-C	Immune Globulin (Human) IV or Subcutaneous	166	$ 3,866.10	$ 641,772.48	$ 74,700.00
	HIZENTRA	Immune Globulin (Human) Subcutaneous	140	$ 8,075.47	$ 1,130,565.32	$ 63,000.00
Infection	CUBICIN, DAPTOMYCIN	Daptomycin	124	$ 866.73	$ 107,474.60	$ 55,800.00
Inflammatory Conditions	ORENCIA	Abatacept	25	$ 3,212.47	$ 80,311.82	$ 11,250.00
	BENLYSTA	Belimumab	111	$ 2,649.30	$ 294,072.80	$ 49,950.00
	CIMZIA	Certolizumab Pegol	49	$ 2,313.01	$ 113,337.59	$ 22,050.00
	SIMPONI	Golimumab	71	$ 2,471.67	$ 175,488.91	$ 31,950.00
	REMICADE	Infliximab	176	$ 3,798.98	$ 668,620.25	$ 79,200.00
	ACTEMRA	Tocilizumab	185	$ 1,646.86	$ 304,669.56	$ 83,250.00
	STELARA	Ustekinumab (IV)	21	$ 16,365.79	$ 343,681.57	$ 9,450.00
	ENTYVIO	Vedolizumab	128	$ 9,026.01	$ 1,155,329.18	$ 57,600.00
Miscellaneous Specialty Condition	DYSPORT	AbobotulinumtoxinA	8	$ 2,473.93	$ 19,791.40	$ 3,600.00
	XIAFLEX	Collagenase Clostridium Histolyticum	39	$ 3,321.10	$ 129,522.79	$ 17,550.00
	SOLIRIS	Eculizumab	27	$ 67,512.27	$ 1,822,831.35	$ 12,150.00
	MAKENA	Hydroxyprogesterone Caproate (Antineoplastic)	3	$ 1,306.88	$ 3,920.64	$ 1,350.00
	XEOMIN	IncobotulinumtoxinA	4	$ 542.41	$ 2,169.62	$ 1,800.00
	Naltrexone	Naltrexone	9	$ 3,092.84	$ 27,835.55	$ 4,050.00
	BOTOX	OnabotulinumtoxinA	483	$ 1,205.69	$ 582,349.71	$ 217,350.00
	Ziconotide Acetate	Ziconotide Acetate	3	$ 5,240.00	$ 15,720.00	$ 1,350.00
Multiple Sclerosis (MS)	TYSABRI	Natalizumab	135	$ 10,202.71	$ 1,377,366.04	$ 60,750.00
	OCREVUS	Ocrelizumab	80	$ 45,235.35	$ 3,618,827.82	$ 36,000.00
Muscular Dystrophy	RADICAVA	Edaravone	28	$ 12,472.17	$ 349,220.80	$ 12,600.00
Ophthalmic Conditions	EYLEA, ZALTRAP	Aflibercept	466	$ 2,247.11	$ 1,047,153.89	$ 209,700.00
	OZURDEX	Dexamethasone (Ophth)	19	$ 1,570.30	$ 29,835.67	$ 8,550.00
	LUCENTIS	Ranibizumab	41	$ 1,603.78	$ 65,754.99	$ 18,450.00
Osteoarthritis	GEL-ONE	Cross-Linked Hyaluronate	11	$ 896.44	$ 9,860.79	$ 4,950.00
	MONOVISC, ORTHOVISC	Hyaluronan	66	$ 877.16	$ 57,892.45	$ 29,700.00
	SYNVISC	Hylan	113	$ 678.12	$ 76,628.04	$ 50,850.00
Osteoporosis	PROLIA, XGEVA	Denosumab	482	$ 2,112.72	$ 1,018,329.36	$ 216,900.00
	Romosozumab-aqqg	Romosozumab-aqqg	62	$ 1,835.64	$ 113,809.81	$ 27,900.00
Thrombolytic	Alteplase	Alteplase	74	$ 1,172.35	$ 86,753.90	$ 33,300.00
Transplant	NULOJIX	Belatacept	87	$ 810.40	$ 70,504.60	$ 39,150.00
	CYTOXAN, NEOSAR	Cyclophosphamide	97	$ 1,261.60	$ 122,375.51	$ 43,650.00
	Mycophenolate Sodium	Mycophenolate Sodium	59	$ 504.95	$ 29,791.93	$ 26,550.00
	Tacrolimus	Tacrolimus	7	$ 917.85	$ 6,424.92	$ 3,150.00
					Potential Savings (Rebates of $450/Prescription)	$ 2,692,800.00

Duplicative Reimbursement

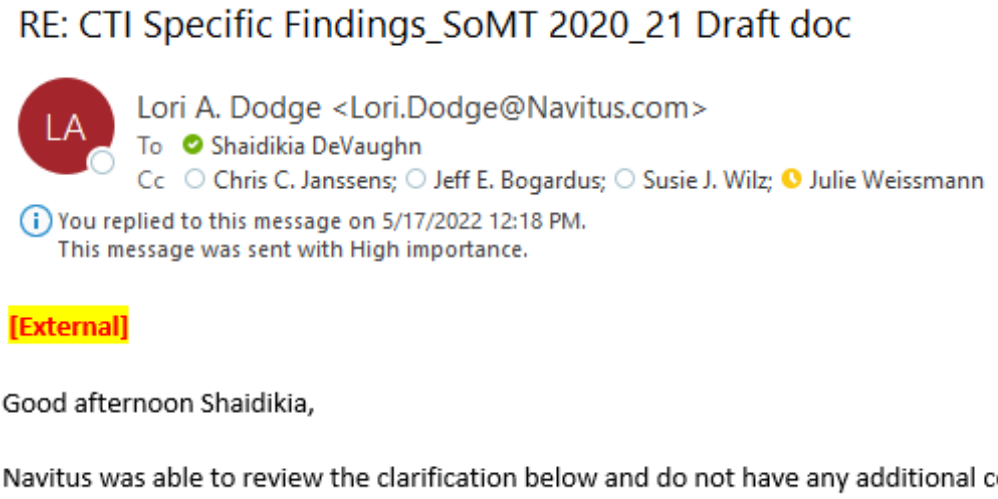
PillarRx analyzes claims to determine whether the medical and a pharmacy benefit were being billed for the same drug for the same member at the same time. Duplicate therapy is a wasteful practice that allows a subscriber and/or provider to be paid simultaneously and is a prevalent and costly issue. This analysis is designed to help you avoid double payments and any potential associated waste.

PillarRx reviews the State's data to identify any potential duplicative reimbursement circumstances. For the State, PillarRx identified no members who received the same specialty medication from both the medical benefit and the pharmacy benefit at the same time. Our analysis compares the fill date on the pharmacy claim to the incurred date on the medical claim for the same drug. If the difference between those dates was less than 15 days, it was considered a potential situation of double-dipping.

PillarRx found there was no overlap in coverage between medical and pharmacy claims for the State.

APPENDIX – ADMINISTRATOR RESPONSE TO DRAFT REPORT

Navitus notes that the above is appropriate and accurate and requires no additional comments.



RE: CTI Specific Findings_SoMT 2020_21 Draft doc

LA

Lori A. Dodge <Lori.Dodge@Navitus.com>
To Shaidikia DeVaughn
Cc Chris C. Janssens; Jeff E. Bogardus; Susie J. Wilz; Julie Weissmann

You replied to this message on 5/17/2022 12:18 PM.
This message was sent with High importance.

[External]

Good afternoon Shaidikia,

Navitus was able to review the clarification below and do not have any additional comments.

CLAIM TECHNOLOGIES INCORPORATED

100 Court Avenue – Suite 306 • Des Moines, IA 50309

Telephone: (515) 244-7322 • Fax: (515) 244-8650 • Website: claimtechnologies.com